

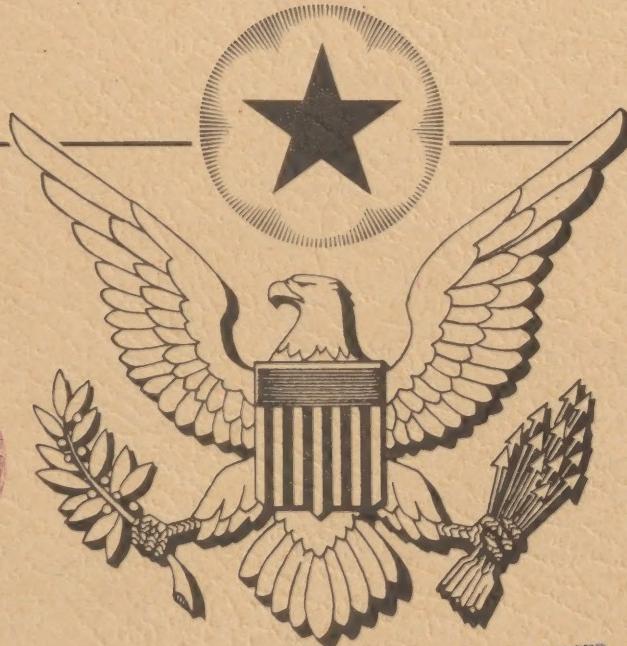
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# MONTHLY PROGRESS REPORT ★ SECTION 7

SPMC 24

# HEALTH



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20 Feb 46 Date *Lewis W. Shelton*  
LEWIS W. SHELTON  
1st Lt. T. C.

**30 SEPTEMBER 1945**

31

MEDICAL INTELLIGENCE  
DIVISION, NO. 1 C-3204

ARMY SERVICE FORCES ★ WAR DEPARTMENT



# HEALTH

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## SUMMARY

MEDICAL ASPECTS OF RYUKYUS CAMPAIGN Casualties were the most severe of any large-scale Pacific operation. Rates for wounded and for psychiatric casualties approximate those reported in Europe. The unexpectedly low incidence of disease coupled with a large, well handled volume of evacuation combined to ease the load on the generally insufficient number of hospitals available. The need for evacuation hospitals in Pacific operations was again underscored. For the first time in the Pacific, air evacuation from the target area almost equalled the volume lifted by water. (See pages 2-10)

NONEFFECTIVE RATES In August for the first time since January 1943 the Z/I noneffective rate (corrected to exclude evacuees) was lower than that for troops overseas. Both rates now stand at the lowest levels of the war. Including evacuees, the noneffective rate for the Army as a whole is lower than at any time since October 1944. (See pages 11-12)

ADMISSION RATES August admissions to hospitals were slightly below those for July, amounting to 313,000 patients overseas and in the Z/I. Only in the Asiatic theaters have total (hospital and quarters) admission rates for disease increased appreciably in recent months, and there they are only 60 percent of the level of previous years. (See pages 13-14)

VENEREAL DISEASE Venereal disease admission rates have reached their highest levels of the war period and are still rising in Europe. (See page 15)

MORBIDITY IN THE PHILIPPINES The incidence of disease in the Philippines continues to be unfavorably high. Following cessation of combat the rates for many nonbattle causes have declined but the increase in respiratory disease has just about offset the gain. (See page 16)

POLIOMYELITIS The relative incidence of poliomyelitis among Army troops in the United States will be higher this year than at any time during the war period although civilian incidence will not exceed the peak of 1944. (See page 17)

HOSPITALIZATION OVERSEAS The hospital population overseas at the end of August was only 100,000, half that on 31 May. There remained only 14 wounded in the European Theater and only about 1,500 in all theaters. Fixed bed authorizations in the European and Mediterranean Theaters were reduced to 4.0 percent on 15 September, and that for the entire Pacific is shortly to be reduced to 4.8 percent of strength. By 10 October 89,000 beds in field, station and general hospitals, and convalescent centers had been returned to the Z/I from the European theaters. (See pages 18 to 20)

EVACUATION The number of Army patients received from overseas during September was 18,000 the smallest since November 1944. (See page 21)

HOSPITALIZATION IN Z/I The general and convalescent hospital population, including patients on furlough, was composed of 201,000 patients at the end of September, 25,000 below the 31 August census. However, the number of occupied beds in general and convalescent hospitals declined by only about 10,000. Plans have been computed for the closure of 20 general hospitals by 31 December. The authorizations for station and regional hospitals were reduced by 2,900 during September and the patient load declined slightly. (See pages 22 to 24)

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## DISEASE AND INJURY

### MEDICAL ASPECTS OF THE RYUKYUS CAMPAIGN

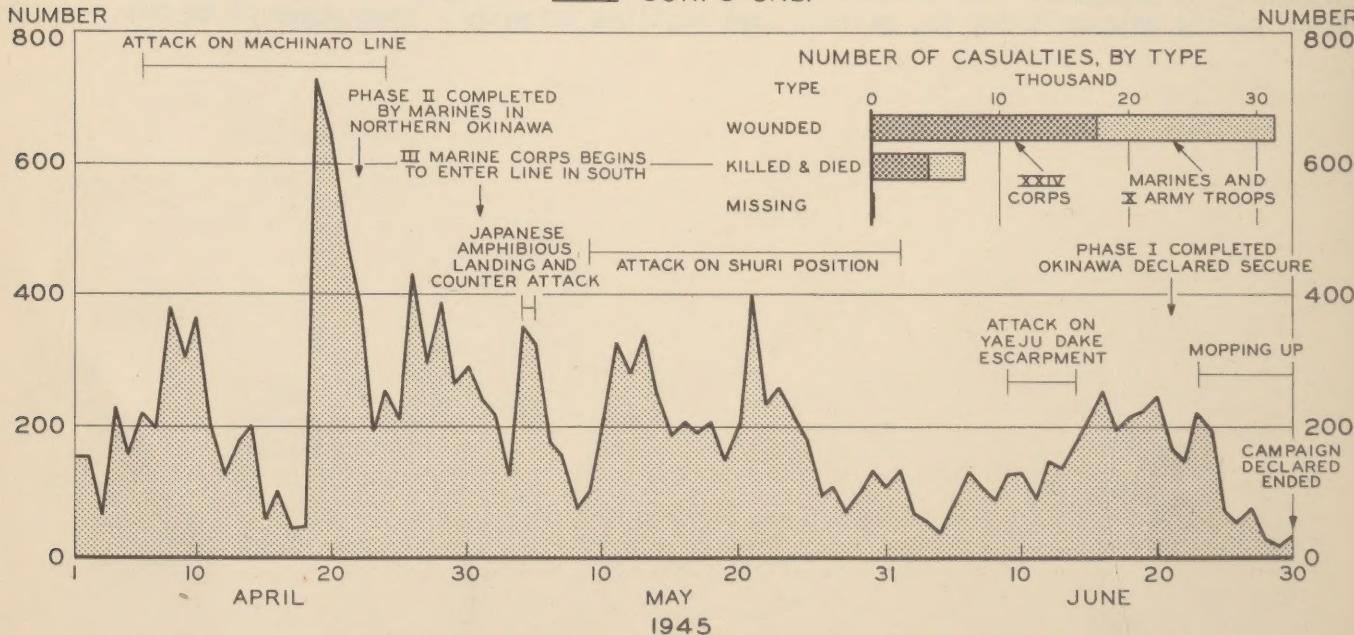
As the final land operation against Japan, and the first major land breach of her home defenses, the Ryukyus Campaign revealed both the medical progress made in the Pacific war and the imperative need for increased medical support of combat troops then destined to fight on the main Japanese islands. The casualty rates experienced by the Tenth Army are high by any standard. The disease picture, studied with great care for its value in planning the assault on Kyushu and Honshu, proved far more favorable than had been anticipated. Both water and air evacuation facilities were more ample and better organized than in any previous Pacific operation. The psychiatric problem assumed new importance for Pacific warfare, approximating that experienced in Europe. Although the mobile hospital support provided for combat troops was superior to that of any previous amphibious operation in the Pacific Ocean Areas, it proved inadequate both as to number and type of units. Supply was generally satisfactory despite delays in unloading. The organization of medical care for civilians was more adequate than in any previous Pacific operation but the need for still further improvements was manifest.

#### Battle Casualties

For the assault on Okinawa and surrounding islands in the Ryukyu Archipelago the Fifth Fleet assembled the largest amphibious task force ever massed in the Pacific. Its mission was to seize a major base from which to mount attacks on the Islands of Japan and their sea approaches, to support further operations in regions bordering on the East China Sea, and to sever Japanese sea and air communications between the home islands and the mainland of Asia, Formosa, Malaya, and the Netherlands East Indies. In addition to a naval force of more than 1,600 vessels manned by over 350,000 Navy personnel, the task force included 200,000 troops of the Island Command and the Tenth Army which was composed of the following: III Marine Amphibious Corps with the 1st and 6th Marine divisions organized as the Northern Landing Force; XXIV Army Corps with the 7th and 96th Infantry Divisions organized as the Southern Landing Force; and the Western Islands Attack Force consisting principally of the 77th Infantry Division. The 2nd Marine Division acted as a demonstration landing group but only one regimental combat team of this division was committed. The 27th Infantry was designated as the floating reserve, and the 81st Infantry Division was the unused area reserve.

The operation began on 17 March with carrier strikes and strategic air force bombardment of Japan and the entire Ryukyu island chain. Carrier forces later provided tactical support at Okinawa, and destroyed the one hostile surface force which the enemy employed. The first landings were made in the Kerama Retto on L-6 by the 77th Infantry Division which secured Kerama Retto and Keise Shima by 31 March. On 1 April Northern and Southern Landing Forces of the Tenth Army landed over the beaches of western Okinawa against very light opposition as the Marine demonstration division feinted a landing on the southeastern beaches. Advancing against virtually no opposition, the landing force split the island in two by L+2.

### NUMBER OF MEN WOUNDED DAILY DURING RYUKYUS CAMPAIGN XXIV CORPS ONLY\*



\* Excludes Ie Shima and Kerama Retto.

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## DISEASE AND INJURY

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## MEDICAL ASPECTS OF THE RYUKYUS CAMPAIGN (Continued)

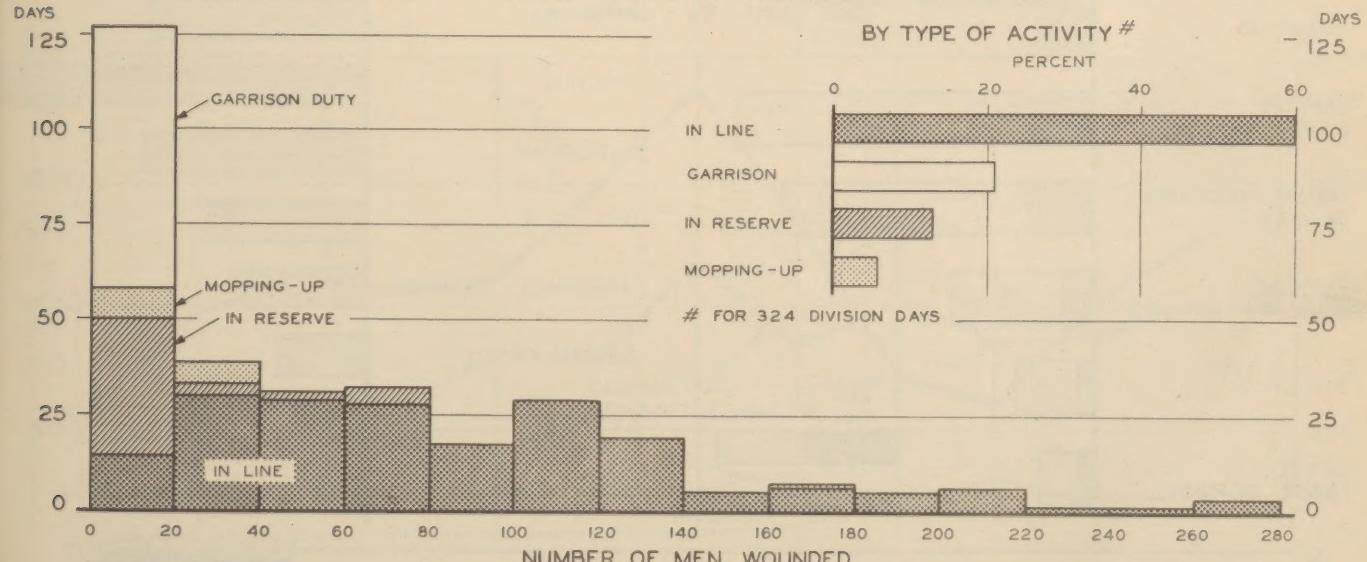
The enemy had accurately anticipated landings in force during March or April and refused to risk his artillery in an attempt to repel the initial assault, choosing rather to deploy it more favorably in the hills where he had carefully prepared underground positions, excellent observation and defilade, and complete knowledge of the terrain forward of his artillery. Protraction of the land warfare was expected to give suicide units an opportunity to wipe out U. S. air and naval forces.

Advancing rapidly northward against little opposition the Marines secured the northern part of Okinawa by 22 April in an action which paved the way for the 77th Infantry Division to land on Ie Shima on 16 April. This island also was secured by 22 April. In the south, the XXIV Corps soon met stiff opposition. On 15 April the 27th Division was moved into line as a unit after one of its regimental combat teams had secured the islands off the east coast of Okinawa. On 19 April the XXIV Corps launched a full-scale attack against the Machinato Line, bitterly defended since 6 April from prepared enemy positions, and broke that line on 24 April. Then it advanced to the Shuri Line, also consisting of deep belts of heavily fortified positions. At the beginning of May the III Marine Corps relieved the 27th Division and the 77th Division joined the main forces on Okinawa. Despite bad weather and the unfavorable terrain, the Tenth Army shattered the Shuri stronghold by the end of May, using four or five divisions organized in the two corps. The enemy force was shortly broken up into increasingly smaller pockets of fanatical resistance, and on 21 June the island was declared secured, but the campaign was not officially terminated until 30 June.

For the naval forces the operation was also difficult, suicide air attacks being directed at fleet units from Kyushu and Formosa in vicious and effective fashion. About 250 ships in the target area were damaged, of which at least 30 were lost.

The progress of the fighting during the capture of the southern portion of Okinawa is indicated in the chart above showing the number wounded in the XXIV Corps each day, as well as some of the more important dates and intervals of the campaign. The medical plan of the Tenth Army presupposed 30,000 battle casualties in the first 60 days, 6,600 killed or fatally wounded and 23,400 living wounded. In this period there were actually 4,100 killed or fatally wounded and 22,600 living wounded. No estimate of the casualties beyond 60 days was made because of the uncertainties of the tactical situation. During the entire 91-day campaign the ground forces participating in the operation sustained 38,900 battle casualties, 7,300 killed in action or fatally wounded, 31,400 living wounded, and 200 missing. In addition, naval personnel aboard ships in the target area sustained 5,000 killed and missing and just under 5,000 wounded through 27 May alone. This ratio of one killed to one wounded is much higher than that of one to 4.3 for ground forces.

Its severe casualty experience makes the Ryukyus Campaign one of the most costly of the war in proportion to the strength engaged. The Tenth Army sustained casualties at the

NUMBER OF MEN WOUNDED PER ARMY DIVISION PER DAY, BY TYPE OF ACTIVITY  
XXIV CORPS IN RYUKYUS \*

\* Excludes 77th Division in Kerama Retto and on Ie Shima

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## DISEASE AND INJURY

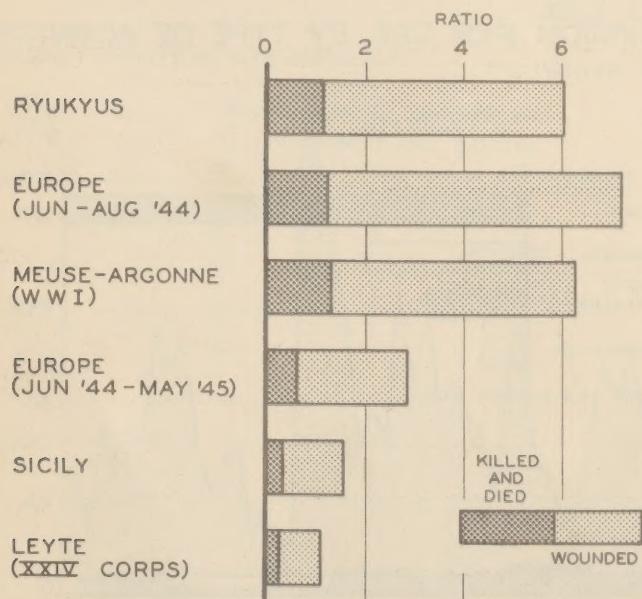
### MEDICAL ASPECTS OF THE RYUKYUS CAMPAIGN (Continued)

rate of 0.66 men killed, 2.87 wounded, and 0.02 missing per thousand strength per day. The army rate of 1.09 killed, wounded, and missing in the Sicilian Campaign is only about one-third as large. The rates for the field armies in Northern Europe during the first three months of the campaign in France were 0.64 men killed and 2.93 men wounded per thousand men per day. However for the entire European operation these rates were 0.33 and 1.19 for killed and wounded respectively. The first three months of the European Campaign were more severe with respect to casualties, however, than is revealed by the army rates. The proportion of service personnel in the field armies in the European Theater was greater than in the Tenth Army on Okinawa where the Island Command performed many of the functions normally within the province of the rear echelons of a field army. If the proportions of service troops had been the same, the European rates would have been higher. The experience of the American First Army during the Meuse-Argonne campaign of World War I (for which counts of missing are unobtainable) was 2.69 per thousand strength per day (excluding gassed), only about three-quarters of that for the Tenth Army. Similar differences exist at the corps level. Only in the Marine operation on Iwo Jima were corps rates experienced in the Pacific which exceeded those for Okinawa, being 1.13 and 4.90 respectively. The chart at the bottom of the previous page gives the distribution of the number of men wounded per division per day in the four Army divisions which participated in the operation. These divisions spent 324 days in the Ryukyus between 1 April and 30 June after being committed, of which 60 percent were combat days. The average divisional casualty rates for various campaigns are compared in the left-hand panel below.

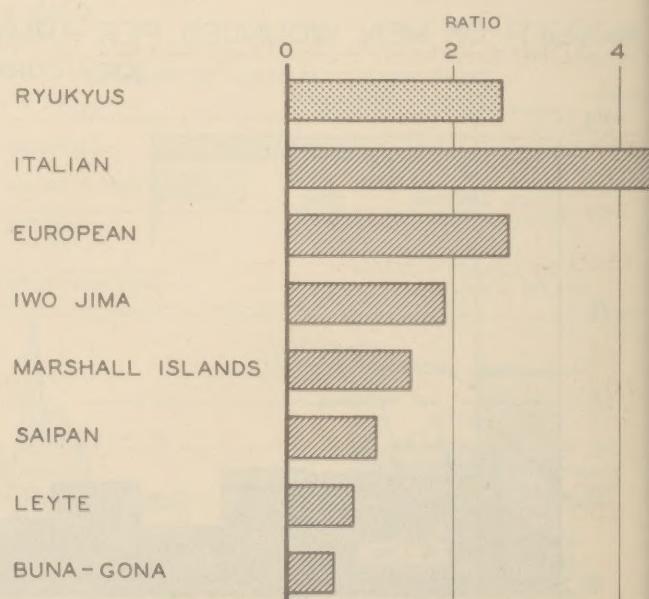
On Okinawa, for the first time in the Pacific, the Japanese made intensive use of artillery. As a result the distribution of wounds by causative agent differs quite markedly from that experienced in past Pacific campaigns and resembles those of the European campaigns. The panel below and to the right compares the Okinawa operation with various European and Pacific campaigns with respect to the number of living wounded hit by shrapnel for every one hit by small arms fire.

Some months prior to the landing on Okinawa the Japanese garrison was estimated at about 55,000 men. This number was increased to approximately 80,000 shortly after L-Day. However, Tenth Army estimates of enemy casualties total 131,300 killed and 10,700 prisoners, including Okinawans conscripted for labor and service. Perhaps 110,000 of the killed and 7,400 of the prisoners were Japanese soldiers. In sharp contrast to the ratios of Japanese killed to U. S. combat deaths in the previous major amphibious operations in the Pacific Ocean Areas, namely five to one in the Gilberts, nine to one in the Marianas, and four to one on Iwo Jima, 15 Japanese were killed during the Ryukyus Campaign for every American. The ratio was 22 to one for Leyte and Luzon, the only other large Pacific operations.

**DIVISIONAL CASUALTIES  
RATES PER THOUSAND MEN PER DAY**



**RATIO OF SHRAPNEL WOUNDS TO GUNSHOT WOUNDS, LIVING WOUNDED ONLY**



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# DISEASE AND INJURY

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## MEDICAL ASPECTS OF THE RYUKYUS CAMPAIGN (Continued)

### CAMPAIGN CASUALTIES IN THE RYUKYUS a/ 1 April through 30 June 1945

Echelon or Component	Days <u>b/</u>	Estimated Average Daily Strength	Number of Casualties			Rates per Thousand Men per Day		
			Killed	Wounded	Missing	Killed	Wounded	Missing
Army								
All Troops	91	120,400	7,247	31,430	200	0.66	2.87	0.02
Army	91	69,200	4,468	17,821	81	0.71	2.83	0.01
Marine	91	51,200	2,779	13,609	119	0.60	2.92	0.03
Corps <u>c/</u>	91	99,500	7,191	31,298	200	0.79	3.46	0.02
Divisions <u>c/</u>	91	69,100	7,101	30,803	196	1.13	4.90	0.03

a/ Excludes Kerama Retto.

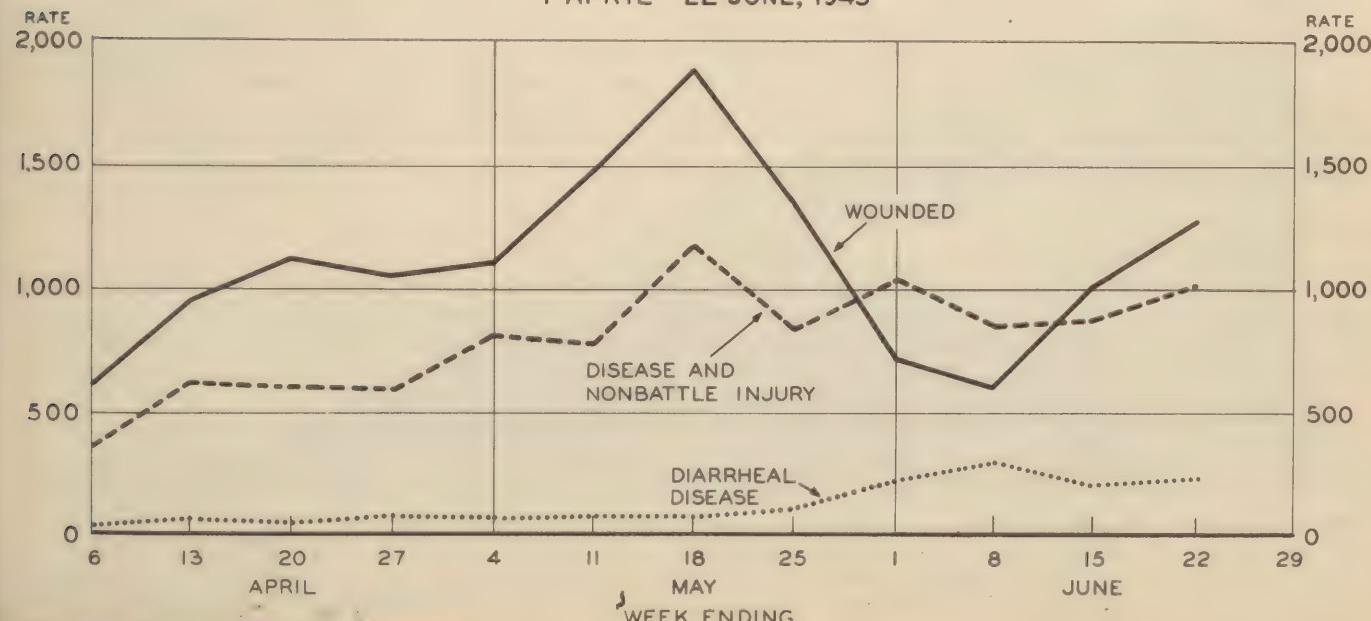
b/ Includes mopping-up period from 22 June - 30 June 1945 inclusive.

c/ Includes both Army and Marine personnel.

### Disease and Injury

During most of the operation the losses from disease were surprisingly low for all forces engaged, but during the last month of combat a significant rise in morbidity occurred. Prior intelligence proved fairly reliable as to the wide variety of diseases to be encountered, but unreliable as to their prevalence. The poisonous snakes reputed to infest Okinawa proved to be a very minor problem, with only a dozen cases of snakebite, none fatal, reported by the III Amphibious Corps. For the Tenth Army, admissions from 1 April through 22 June numbered 22,000 for disease and nonbattle injury and 30,000 wounded. Operational reports fail to make it quite definite that quarters admissions are included but it is assumed here that they are. The accompanying chart gives the weekly rates throughout the campaign. Difficulties of obtaining comparable reports on disease and nonbattle injury from Marine and Army troops prevent any clear-cut distinction between disease and injury, which are combined in the chart. However, it is plain that the incidence of disease increased considerably toward the end of the campaign, primarily because of diarrheal disease. The diarrheal disease rates of 200 to 300 per thousand men per year reached in June are well in excess of those reported by the Sixth Army on Luzon (see HEALTH for June). The primitive standards of the natives, the destruction and debris of battle, the unburied dead, and the large fly population all contrived to create a severe problem of sanitation, especially in the south and toward the end of the operation. Airplane spraying of DDT provided only a very limited control over fly breeding, the more usual methods of control being indispensable. Notably low was the incidence of both malaria and dengue, and no evidence of schistosomiasis was found.

### ADMISSIONS PER THOUSAND MEN PER YEAR, TENTH ARMY IN RYUKYUS 1 APRIL - 22 JUNE, 1945



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## DISEASE AND INJURY

### MEDICAL ASPECTS OF THE RYUKYUS CAMPAIGN (Continued)

during the combat period. The dengue which was reported as such was all or chiefly in one Army division, and there is doubt concerning its true identity on both clinical and epidemiological grounds. Very few malaria infections were found in the civilian population. The extensive use of DDT and other anti-mosquito measures effectively minimized the risk of transmission from local sources or from military personnel previously infected in other areas. Airplane spraying of DDT was begun about L+1 by carrier-based planes and later taken over by C-47's. All troops were on suppressive atabrine, and virtually all the reported cases of malaria are thought to have been recurrences of infections acquired elsewhere. Filariasis was found in 20 to 30 percent of the natives examined; since clinical symptoms do not usually develop until three to nine months after exposure, only time will tell whether this disease was transmitted to any U. S. troops. Japanese B encephalitis, an epidemic disease found in Japan and on the Asiatic mainland, was later identified but its numerical incidence was small.

Providing the outstanding medical problem of the operation, neuropsychiatric admissions to Tenth Army field hospitals numbered 4,300. However, a large number of "exhaustion" patients was returned to duty by aid stations and clearing stations and does not appear in the hospital admission statistics. In the four divisions of the XXIV Corps alone there were 3,222 admissions to clearing stations, making a ratio of one psychiatric case per five wounded. Although comparable Marine Corps psychiatric casualties are not available, it is believed that they at least equalled those reported by Army divisions. The ratio of one to five is identical with that for fighting in France in July and August 1944 and represents an admission rate of 1.0 per thousand per day, slightly higher than that experienced in France (see *HEALTH* for October 1944). The Ryukyus probably saw the greatest incidence of psychiatric casualties ever experienced by Army troops in the Pacific. All reports specify the intensity of combat and the extensive use of artillery by the Japanese as the major factors. Battle casualties were numerous and severe. Although the Japanese artillery tactics were not new, the fire-power at their disposal, both as to numbers and calibers of artillery and mortar pieces, was unprecedented in the Pacific. For the Navy the psychiatric problem was especially serious on the small craft assigned to radar picket duty and a need was felt for their more frequent relief.

The neuropsychiatric problem in the Ryukyus campaign is also notable for the organization of psychiatric care. The medical plan called for the provision of a psychiatric team which was first used to establish psychiatric sections in each field hospital. It was soon found that a single center would be preferable, and toward the end of April the 82nd Field Hospital was set up as a special psychiatric treatment center. Also utilized to good advantage for psychiatric casualties were divisional rehabilitation and training camps under line command. Each division had its neuropsychiatrist who handled patients at the division clearing station and superintended their care at forward echelons. In its essential characteristics, therefore, the method of handling psychiatric casualties tended toward that which evolved in Europe without, however, becoming as fully developed. It is the closest approach to the plan recommended by The Surgeon General (see *HEALTH* for July) that the Pacific war produced.

Observations on the proportions of patients returning to duty are complete only for hospital admissions. It is known that about 40 percent were returned to full duty and 10 percent to limited duty. The other 50 percent were evacuated, half because of temporarily crowded bed conditions. At the divisional level one Army division reports a total of 86 percent returned to duty, about half from division installations and half from supporting hospitals.

### Evacuation

Failure of the Japanese to defend the beaches in force assured the success of the plan for seaward evacuation, itself a culmination of experience in previous Pacific amphibious operations, and evacuation from the island proceeded smoothly throughout the campaign. Evacuation among echelons ashore was similarly favored by the early opportunity to organize medical service before the tactical situation became very active. On L-Day, eight LST(H)'s supported the assault divisions from their positions at the reefs bordering the landing beaches. DUKW's and LCVP's bore patients to specified LST(H)'s for triage, holding, and transfer to AH's, APH's, and APA's. There were very few days throughout the operation when such transfer was impossible. Augmented by medical personnel from units scheduled for landing in the later echelons, the LST(H)'s performed emergency surgery and exercised tight control over the flow of patients, thus obviating aimless wandering in search of bed space. Hospital ships were present on L-Day, seven being made available during the operation. Three

# DISEASE AND INJURY

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## MEDICAL ASPECTS OF THE RYUKYUS CAMPAIGN (Continued)

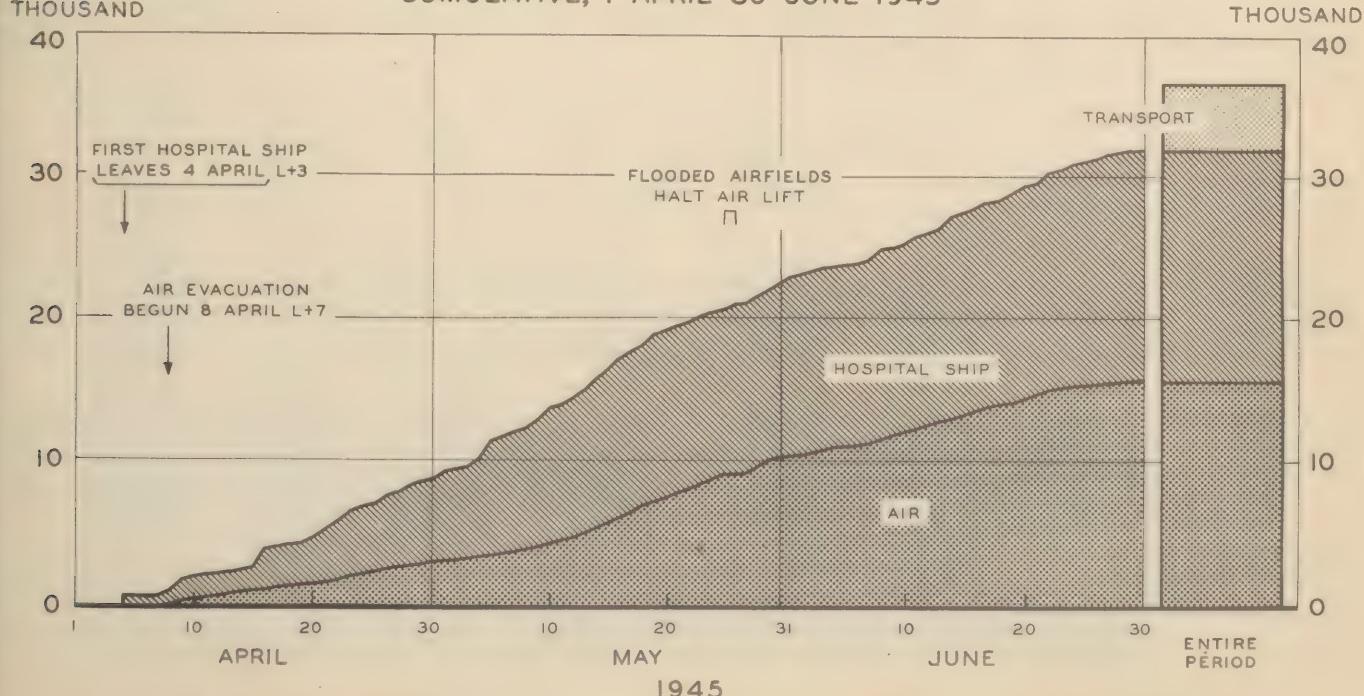
APH's and numerous medically strengthened APA's extended the patient carrying capacity of the fleet. On 2 April and 20 April two hospital ships were attacked with no damage, but on 28 April a third AH was attacked and damaged 50 miles from Okinawa, with 29 killed, and on the same day an APH was also hit, with 22 killed. Thereafter the AH's did not retire at night but lay darkened in the transport area.

From L-Day to L+3, before the field hospitals were ashore, evacuation was immediate and under divisional control. Patients moved from battalion aid stations to divisional clearing stations and portable surgical hospitals on the beaches, and thence to LST(H)'s for further evacuation to ships in the transport area. By L+3 the XXIV Corps medical battalion was operational, evacuating patients from clearing companies to stations set up for holding casualties en route to ships. As the first field hospitals opened, Corps ambulances continued to evacuate the clearing stations, bringing patients to the field hospitals as well as evacuating them to holding points at the beach. Air evacuation was begun on L+7, Army and Navy C-54 planes arriving each morning from Guam on an hourly schedule. By L+10 a strip-side holding station was established by the XXIV Corps. Patients were carefully screened before lift and only one fatality was recorded among the 15,700 patients transported by air to Guam. At the beginning of May, Tenth Army relieved XXIV Corps of responsibility for operation of hospitals and evacuation from them to air and water holding stations. On 7 May the Island Command assumed responsibility for evacuation from Okinawa, establishing its own holding centers. Evacuation of divisional clearing companies continued to be a Corps responsibility, and the Corps clearing companies were able to resume their normal function of supporting Corps troops.

At the end of May heavy rains made ambulance routes impassable. Coastwise evacuation routes were successfully developed by the use of LST(H)'s and returning supply ships. The LST(H)'s arrived off the various beaches early each day and in the evening carried casualties back to field hospitals behind the flooded areas and to ships in the transport area. Even after roads were re-opened evacuation by LST(H) was continued. The III Amphibious Corps also used LST(H)'s in northern Okinawa to provide an easier trip for casualties who would otherwise have suffered a rough ambulance ride, at times in excess of 30 miles. Marine reports recommend heavier ambulances in place of the jeep and other small ambulances, the former being superior in point of comfort, capacity, and maneuverability. As the distance between the front lines and hospitals increased L-5 planes were used to evacuate seriously wounded casualties from the front. By 21 June, when Okinawa was declared secured, 1,200 seriously wounded had been evacuated to rear areas by this means. The Tenth Army has recommended greater reliance upon L-5 planes in operational planning.

## PATIENTS EVACUATED FROM RYUKYUS, BY MEANS OF TRANSPORTATION\*

CUMULATIVE, 1 APRIL-30 JUNE 1945



\* Army, Navy, and Marine Corps Personnel

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## DISEASE AND INJURY

### MEDICAL ASPECTS OF THE RYUKYUS CAMPAIGN (Continued)

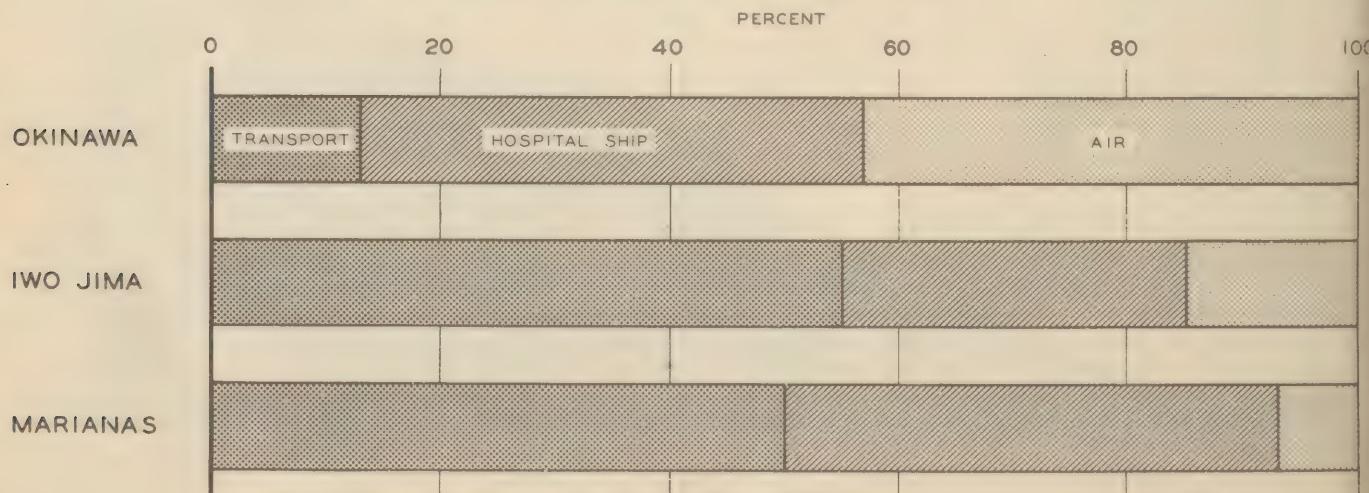
Counts are not available of the numbers of hospital patients who should have been evacuated under a 15-day evacuation policy, but a large number of patients able to return to duty within 14 days was lost by evacuation. It is probable that 36,700 Army, Navy, and Marine Corps patients were evacuated from the target area of which about 31,000 were Tenth Army patients. Of the total number 16,100 were carried by seven hospital ships in 27 separate lifts, 4,900 by other ships, and 15,700 by air. The patients evacuated by water were debarked in the Marianas where credits were provided amounting to 25,000 beds. The panel on the previous page shows the cumulative evacuations from the target area by air and hospital ship, the schedule of transport lifts not being available. The chart below compares the proportions of lift effected by air, hospital ship, and transport during the Iwo Jima, Saipan, and Ryukyus Campaigns. The extensive use made of air evacuation at Okinawa has no parallel among previous amphibious operations. Air evacuation was regarded as remarkably successful, and proved possible on all but two days of the operation once it was in effect. In contrast to the estimated 31,000 men lost by the Tenth Army through evacuation, the 7,400 deaths, and perhaps 5,000 patients in hospital at the end of the operation, the expeditionary forces received replacements numbering 24,000 men, leaving a net loss of about 19,000.

#### Hospitalization

The hospitalization situation on Okinawa was far from satisfactory during the combat phase but it was partially relieved by the excellent facilities available for evacuation. In planning the operation the Tenth Army sought to obtain about 8,000 mobile beds for the assault, but only about 4,500 were provided including portable surgical hospitals and two new Marine Corps evacuation hospitals. In the planning stage no Army evacuation hospitals were available to the Pacific Ocean Areas, the two 750-bed units located in the South Pacific having been previously assigned to the Southwest Pacific Area. Hence it became necessary to strengthen the Army field hospitals as much as possible in order to compensate for their inadequacy as evacuation hospitals. A number of surgeons assigned to units echeloned for late arrival was mounted in the assault, and the professional staff of each hospital in the assault was augmented with specialized talent to the greatest degree possible. Despite its deficiencies the hospital support for Okinawa was superior to that provided for any previous operation in the Pacific Ocean Areas.

In addition to 20,600 estimated wounded admitted to hospital in the first 60 days, the operational plan forecast 41,000 nonbattle admissions to hospital among Army and garrison troops, with projected rates as high as 4.2 per 1,000 men per day. The hospitalization provided, about 3.5 percent of average Tenth Army strength, was considerably short of the anticipated need even on the basis of an evacuation policy as short as ten days. That the actual need was less than predicted stems chiefly from the fact that disease admissions were much lower than anticipated. Although a good estimate of hospital admissions for nonbattle causes is not yet available for the Tenth Army, it is instructive to compare, as in the chart on the next page, the incidence of wounded in relation to mobile bed capacity for the Tenth Army with similar figures for the First, Third, and Seventh Armies which operated in

#### PROPORTION OF PATIENTS EVACUATED BY MEANS OF TRANSPORTATION AMPHIBIOUS OPERATIONS IN MIDDLE PACIFIC



## DISEASE AND INJURY

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## MEDICAL ASPECTS OF THE RYUKYUS CAMPAIGN (Continued)

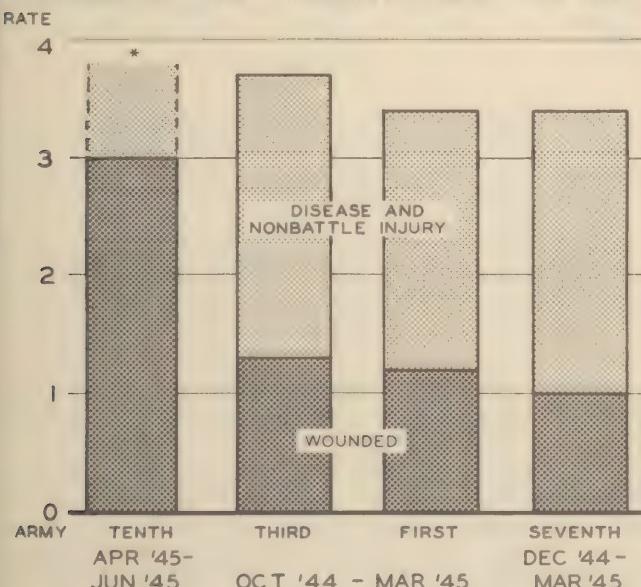
France and Germany. Because ample evacuation facilities were available throughout the operation, Tenth Army hospitals, and later also those under the Island Command, were seldom overcrowded. Since the proportion of wounded was quite high, however, the work of caring for the hospital population was greater than the average census would ordinarily imply.

The heavy load of casualties and of psychiatric patients demonstrated again the inadequacy of field hospitals used as the exclusive hospital support for combat divisions. Despite a very flexible utilization of specialized personnel in order to strengthen the field hospitals, they continued to lack much of the personnel and equipment required by mobile hospitals in tactical employment. Several surgical teams and a psychiatric team were of great value, but there were too few teams to relieve the critical shortage of surgical specialists throughout the operation. Only five of the 12 surgical teams desired by the Tenth Army were provided. Only three neuro-surgeons and two eye surgeons were available. Qualified orthopedic and general surgeons were also limited in number, and no specially trained maxillo-facial or thoracic surgeons were present. Surgery was sometimes appreciably delayed on this account, and it was necessary to evacuate from the island at least 5,200 casualties without admitting them to field hospitals where surgery should have been performed. The operational report of the Tenth Army recommends one field, one evacuation (400 beds), and two portable surgical hospitals per assault division, plus either two evacuation hospitals (400 bed) or one field and one evacuation hospital (400 bed) per corps, and the same for the army. The camps for psychiatric patients and other provisional convalescent facilities furnished some relief but a larger amount of mobile holding capacity was needed for those not seriously ill, the convalescent wounded, and psychiatric patients.

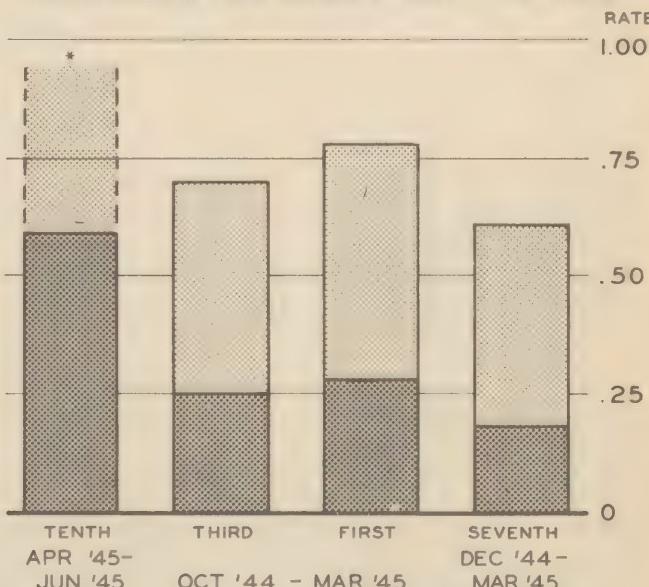
In view of the relative shortage of hospital capacity and the lack of evacuation hospitals it was fortunate that the tactical situation permitted an easy landing and relatively prompt location of hospitals. There were unloading difficulties and some units reported a lack of engineering equipment or assistance in establishing their hospitals, but in general such delays were short. Clearing stations reinforced by portable surgical hospitals were set up ashore on L-Day, and by L+5 two field hospitals were in operation. By L+30 3,000 beds (T/O capacity) had been set up in direct support of the combat units. Three weeks later in the operation army units were reinforced by 1,400 additional beds for garrison forces under the Island Command. By the end of the operation Army and Navy hospitals with a T/O capacity of about 7,000 beds were available in the Ryukyus for both combat and garrison forces, well under four percent of the aggregate strength. At that time in addition to Army and Marine Corps patients there were also 1,065 PW patients in Island Command hospitals, an unprecedented number for the Pacific.

## ADMISSIONS AND MOBILE BED CAPACITY IN VARIOUS ARMIES

## ADMISSIONS PER THOUSAND MEN PER DAY



## ADMISSIONS PER MOBILE BED PER WEEK



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**CONFIDENTIAL**

## DISEASE AND INJURY

### MEDICAL ASPECTS OF THE RYUKYUS CAMPAIGN (Continued)

During the early stages of the operation Navy casualties exceeded landing force casualties, and hospital facilities were urgently needed for wounded personnel of fleet units. As hospital ships were still on night retirement, two APA's were designated to care for wounded and two for unwounded survivors. All three main fleet concentrations had adequate means for emergency medical care as well as evacuation.

#### Civilian Medical Care

In the Ryukyus Campaign special Navy medical units were provided for the treatment and hospitalization of civilians so as to relieve tactical units of this very real burden during combat in a heavily populated area. Although Navy hospitals proved insufficiently mobile during the assault phase, both Navy hospitals and Navy dispensaries functioned well in caring for the civilian sick and wounded. The amount of illness was far less than anticipated, most of the patients requiring surgical treatment. For the most part the forward location of the civilian dispensary units effectively relieved divisional medical installations of all responsibility except for first aid, although there were times when it was necessary to detach medical personnel from tactical units to strengthen the medical facilities for civilians. Military government units concentrated civilians in camps in order to prevent their uncontrolled circulation, the census being about 275,000 at the end of June. Insufficient prior training and experience on the part of unit personnel, and shortages of supplies, equipment, and transportation facilities were reported but were not serious enough to threaten the success of the military government operation.

Sanitation posed a major problem, but it is reported that diarrheal diseases were not very prevalent in the civilian camps. Filariasis and infection with intestinal parasites were commonly found, as were leprosy and tuberculosis. There was very little malaria or dengue during the combat period. On the whole the incidence of communicable disease was fairly satisfactory. Tetanus was frequently observed among the wounded. Self-inflicted wounds were often seen among victims of Japanese terror propaganda to whom humane treatment came as a surprise.

#### Supply

Medical supply was generally adequate throughout the campaign, especially at the divisional level. Each medical unit in the assault mounted with supplies for 30 days. On L-Day XXIV Corps landed a supply team which established a Corps dump from divisional and Corps supplies, and Tenth Army established a dump shortly after L+15. Automatic resupply was originally scheduled through L+210 and was to be effected by four types of medical maintenance units. The M-1 blocks were designed for first and second echelon medical units and 50 were scheduled to land in the first resupply on L+5. The M-2 and M-3 blocks, furnishing non-expendable replacement items and biologicals respectively, were scheduled for landing at various intervals in successive resupplies. The first M-4 blocks, containing both expendable items to supplement the M-1 blocks and items used in field and evacuation hospitals, were scheduled for the fourth resupply beginning L+35. A sufficient number of M-4 blocks was ordered to build up a 90-day reserve by L+180.

At least in part because of bad weather and constant air attacks, unloading of medical supplies proceeded more slowly than planned. The first M-1 blocks were unloaded ten days late. The M-2 and M-3 blocks were 10 to 25 days late. The first M-4 blocks were about 10 days behind schedule. Subsequent shipments were even further delayed, for the Island Command reported that, of 2,061 tons due by L+55, only 611, or less than 30 percent, had been unloaded. As was commented in the summary of the Leyte Campaign (see HEALTH for June), it would appear that, in view of their almost insignificant tonnage, more extensive top-loading of medical supplies could be practiced on resupply ships in order to facilitate unloading.

Certain shortages occurred because of delays in unloading and higher consumption rates than anticipated, so that it became necessary to requisition for air shipment a number of important items, e.g. blankets, cots, X-Ray film, and sutures. Replacement of cots, litters, and blankets lost through misappropriation and imperfect property exchange created a problem in this campaign as in others. DDT supplies were initially rather short and remained on the critical list because of their extensive use. Lack of spare parts frequently necessitated the replacement of items of equipment. On the other hand, and despite the large number of casualties, sufficient whole blood was available wherever and whenever needed throughout the campaign. About 41,000 pints of Group O blood were used, or more than one pint per surgical patient, with virtually no serious reaction.

# DISEASE AND INJURY

## NONEFFECTIVES IN HOSPITAL AND QUARTERS, U. S. AND OVERSEAS

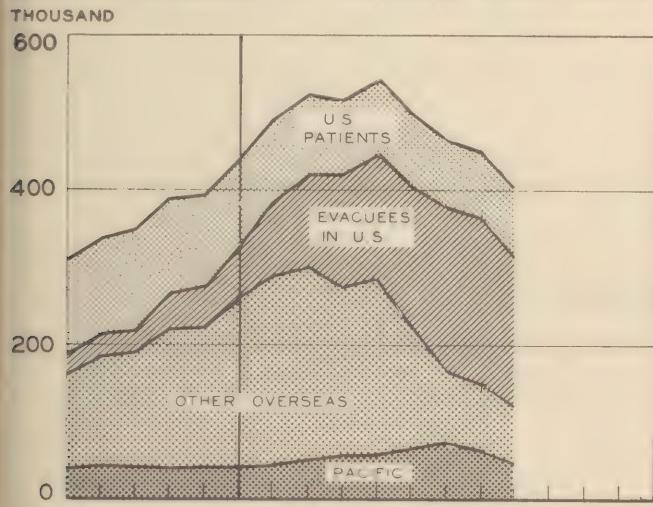
The average number of noneffectives in hospital and quarters throughout the Army continues to decline both absolutely and relatively. The noneffective population of 400,000 men for August is almost ten percent below that for July, while the noneffective rate of 49 per 1,000 strength is four points lower than the figure for July and the lowest rate since October 1944. The largest single component of the noneffective rate remains the overseas patients in Z/I hospitals, numbering almost 200,000 patients and responsible for about half the total rate. Even this segment declined about eight percent in August, however, and it now seems plain that the peak noneffective population in the Z/I was reached with 300,000 in July. In August for the first time since January 1943 the Z/I noneffective rate (corrected to exclude evacuees) exceeded that for troops overseas. Both rates now stand at the lowest level of the war.

The panel below for all Z/I noneffectives, including overseas patients, reveals sharp changes in the wounded component and continued declines in those for disease and nonbattle injury as well. Neuropsychiatric patients, numbering about 30,000 during the month in contrast to 90,000 wounded, represented a noneffective rate of eight per 1,000 Z/I strength. Both the disease and nonbattle injury fractions of the estimated overseas noneffective rate for August are the lowest of the war period, and the wounded portion compares in size with that reported in November 1942, so effective has been the evacuation of wounded to the Z/I.

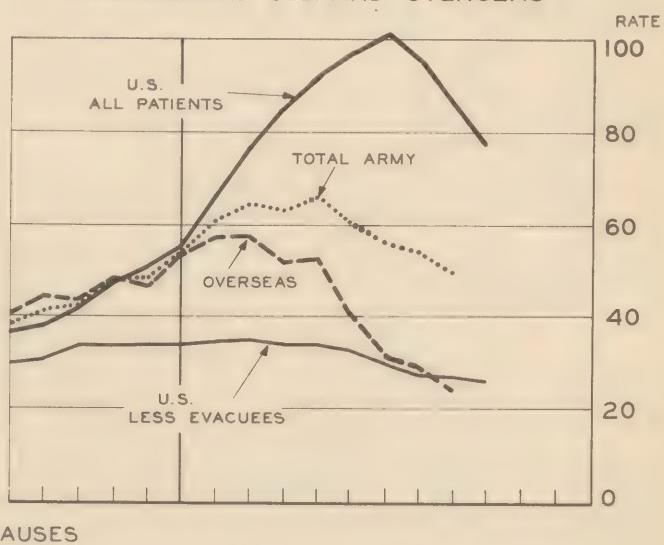
### AVERAGE NUMBER OF NONEFFECTIVES PER THOUSAND STRENGTH

ALL CAUSES

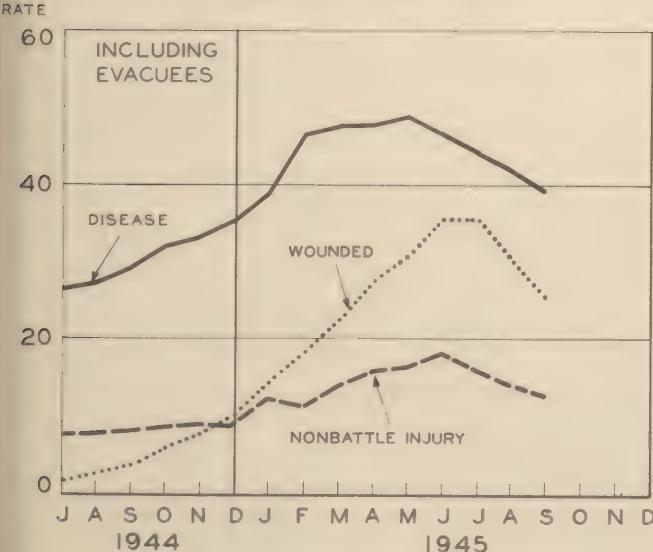
#### AVERAGE NUMBER OF PATIENTS EACH MONTH



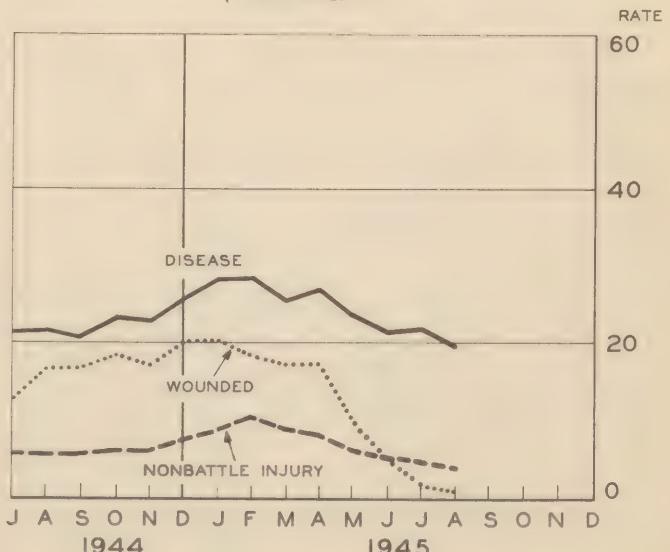
#### CONTINENTAL U.S. AND OVERSEAS



#### CONTINENTAL U.S.



#### OVERSEAS

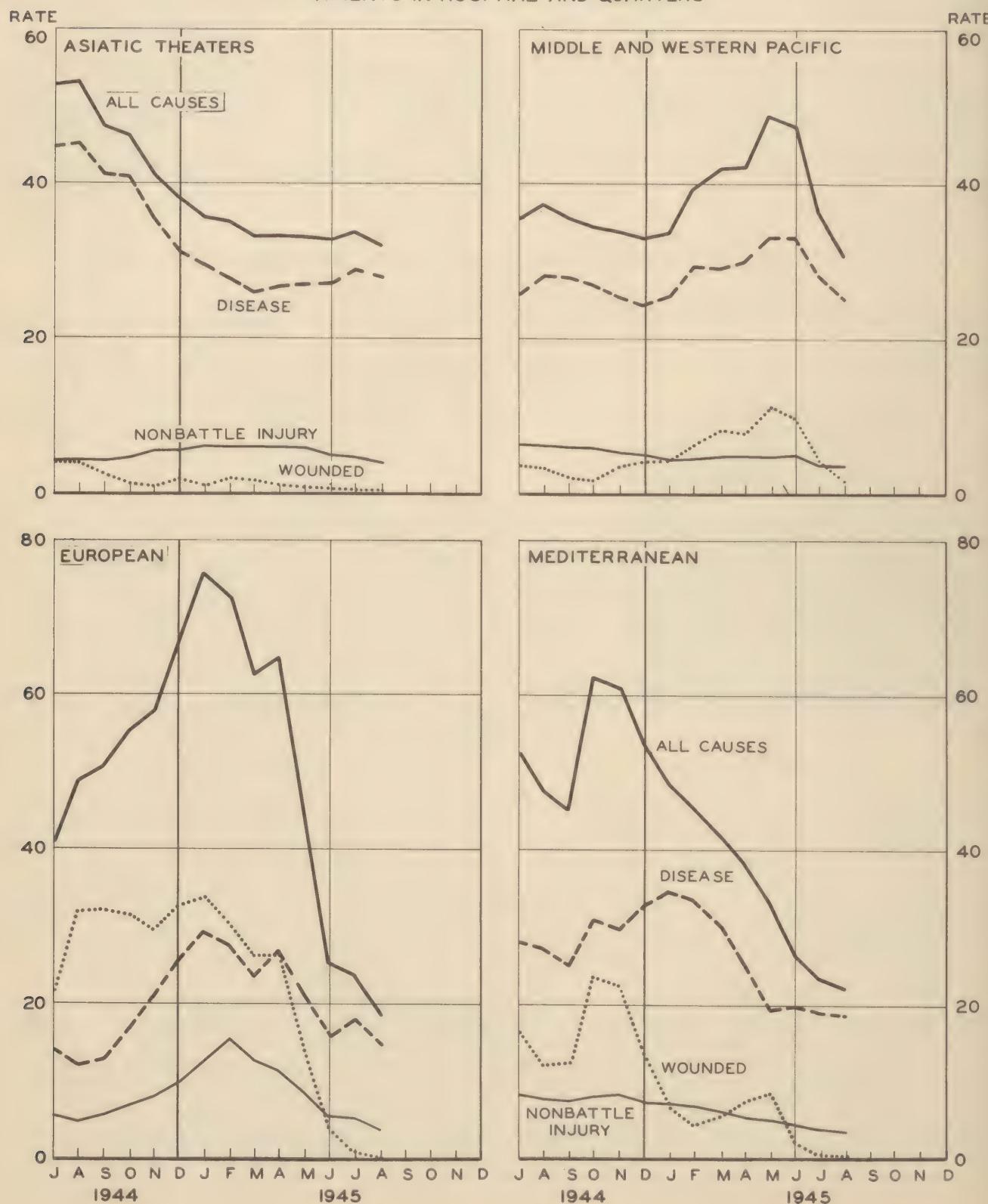


## DISEASE AND INJURY

### NONEFFECTIVES IN HOSPITAL AND QUARTERS, U. S. AND OVERSEAS (Continued)

The panels below present the trends in the major components of the noneffective rates for areas of greatest troop concentration. In the Asiatic theaters, where very high rates have previously occurred in July and August, the current level for disease is most favorable. In the Pacific the rates for both disease and battle casualty declined in July and also in August, according to provisional estimates. The July figures shown in HEALTH for August have been corrected. August rates for the European Theater are also down.

**AVERAGE NUMBER OF NONEFFECTIVES PER THOUSAND STRENGTH  
PATIENTS IN HOSPITAL AND QUARTERS**



# DISEASE AND INJURY

## TREND OF HOSPITAL ADMISSIONS IN THE U. S. AND OVERSEAS

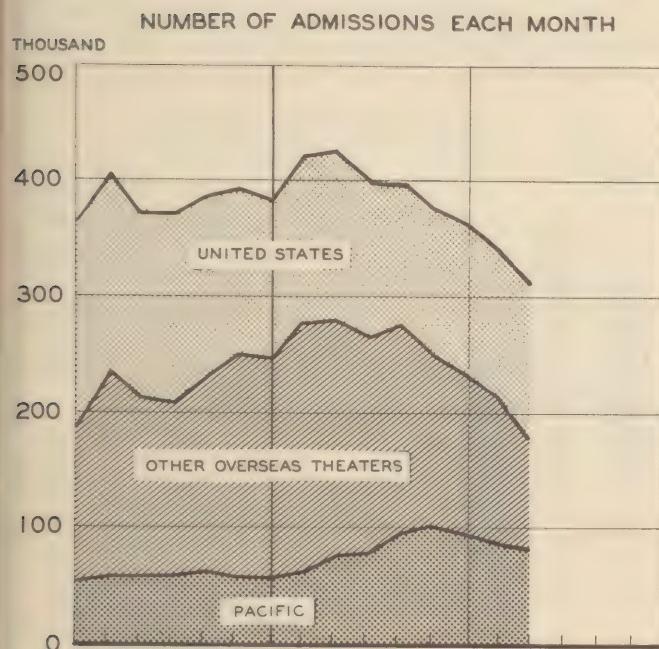
August admission rates to hospital, which exclude the numerous short-duration cases treated in quarters, are slightly below those for July, according to radio reports. About 313,000 Army patients were admitted to hospital directly or transferred to hospitals from non-hospital medical installations during August, about six percent below the July count. For troops in the Z/I there were 133,000 admissions in August, more than in July, but the Z/I strength rose enough to offset the increase in admissions. In September there was a decline of about nine percent in the Z/I admission rate for all causes.

The accompanying panels present the most recent rates and numbers of admissions against the background of the trends since June 1944.

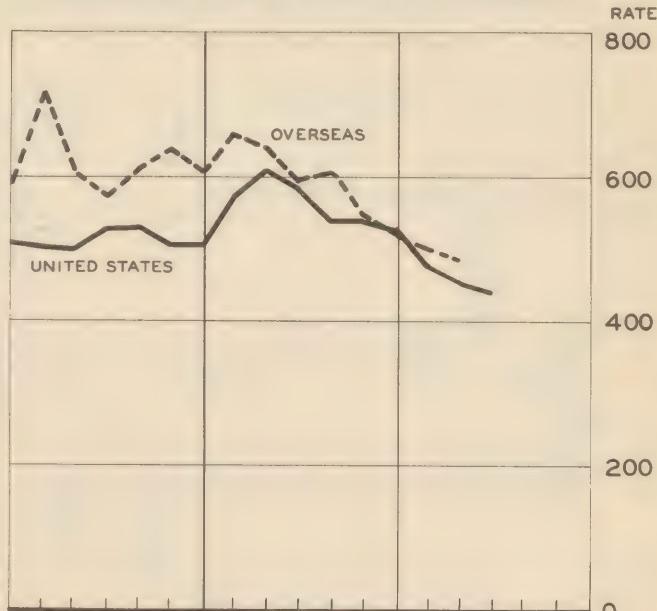
## DISEASE, NONBATTLE INJURY, AND WOUNDED HOSPITAL ADMISSIONS

RATES PER THOUSAND MEN PER YEAR

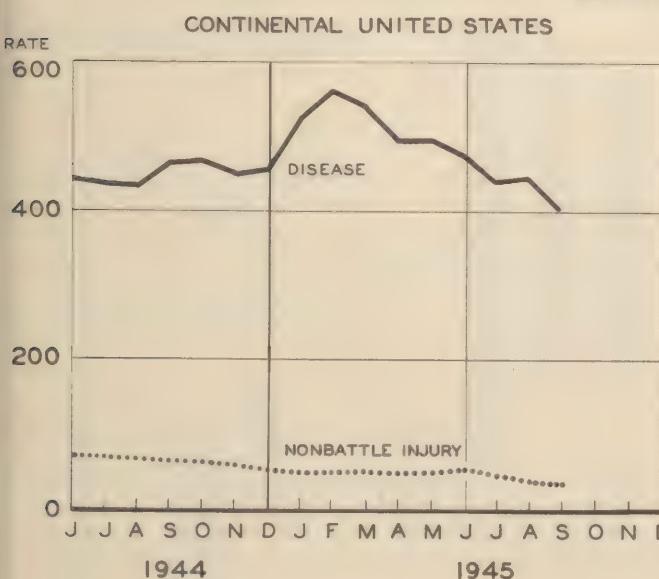
ALL CAUSES



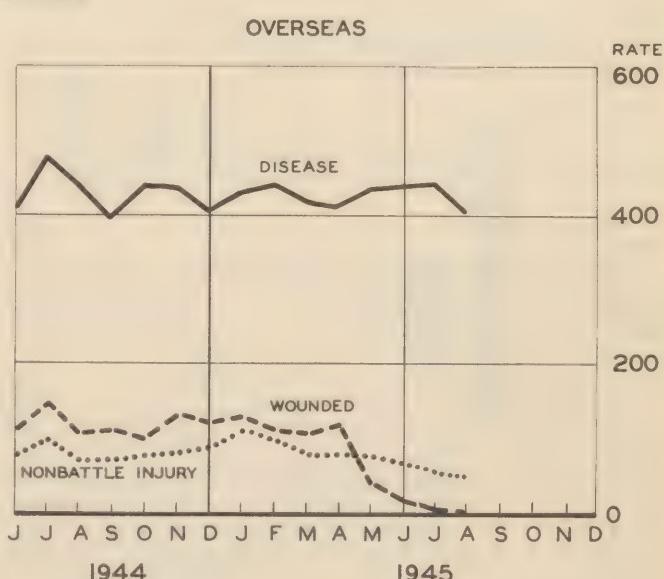
## CONTINENTAL UNITED STATES AND OVERSEAS



## MAJOR CAUSES



## OVERSEAS



# DISEASE AND INJURY

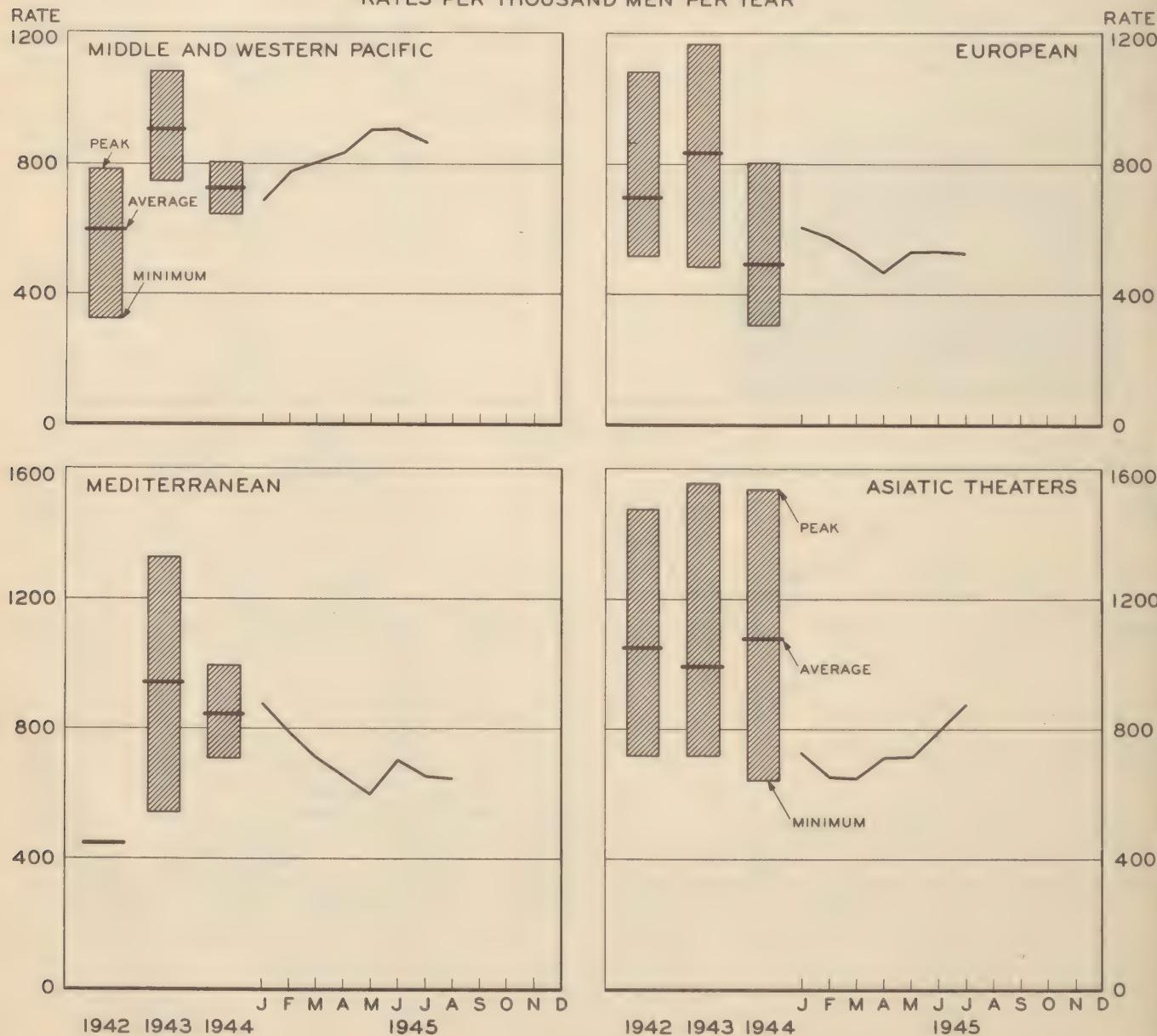
## DISEASE ADMISSIONS TO HOSPITAL AND QUARTERS IN OVERSEAS THEATERS

In comparing the incidence of morbidity in the major overseas theaters it is more convenient to employ admissions to both hospital and quarters than, as on the preceding page, to hospital only. The course of the disease admission rates in the four leading theaters is presented in the charts below from 1942 to date. The bars for 1942, 1943, and 1944 show the range of the monthly rates in each year, the bottom being the minimum and the top the maximum rate for the year. The horizontal line across each bar gives the average for the year. In comparison with the earlier rates those currently reported, shown separately by month for 1945, are quite favorable. The only appreciable change in the newly available rates is in those for the Asiatic theaters where the disease admission rate advanced to 875 for July. However, even this high rate is but 60 percent of the July rates of previous years.

In the Western Pacific, not shown separately on the charts, the July rate is almost 10 percent below the recent peak of 1,140 in May. In Alaska, following the respiratory epidemic in May, disease admission rates continued to fall in July and August. The July and August respiratory disease admissions among troops in Alaska are normal in incidence. The incidence of the respiratory diseases has not yet begun to increase in the United States. The September rate of 79 in fact is less than the rates of 85 and 87 which obtained during July and August, and is less than the rate of 87 for September 1944.

## DISEASE ADMISSIONS TO HOSPITAL AND QUARTERS OVERSEAS

RATES PER THOUSAND MEN PER YEAR



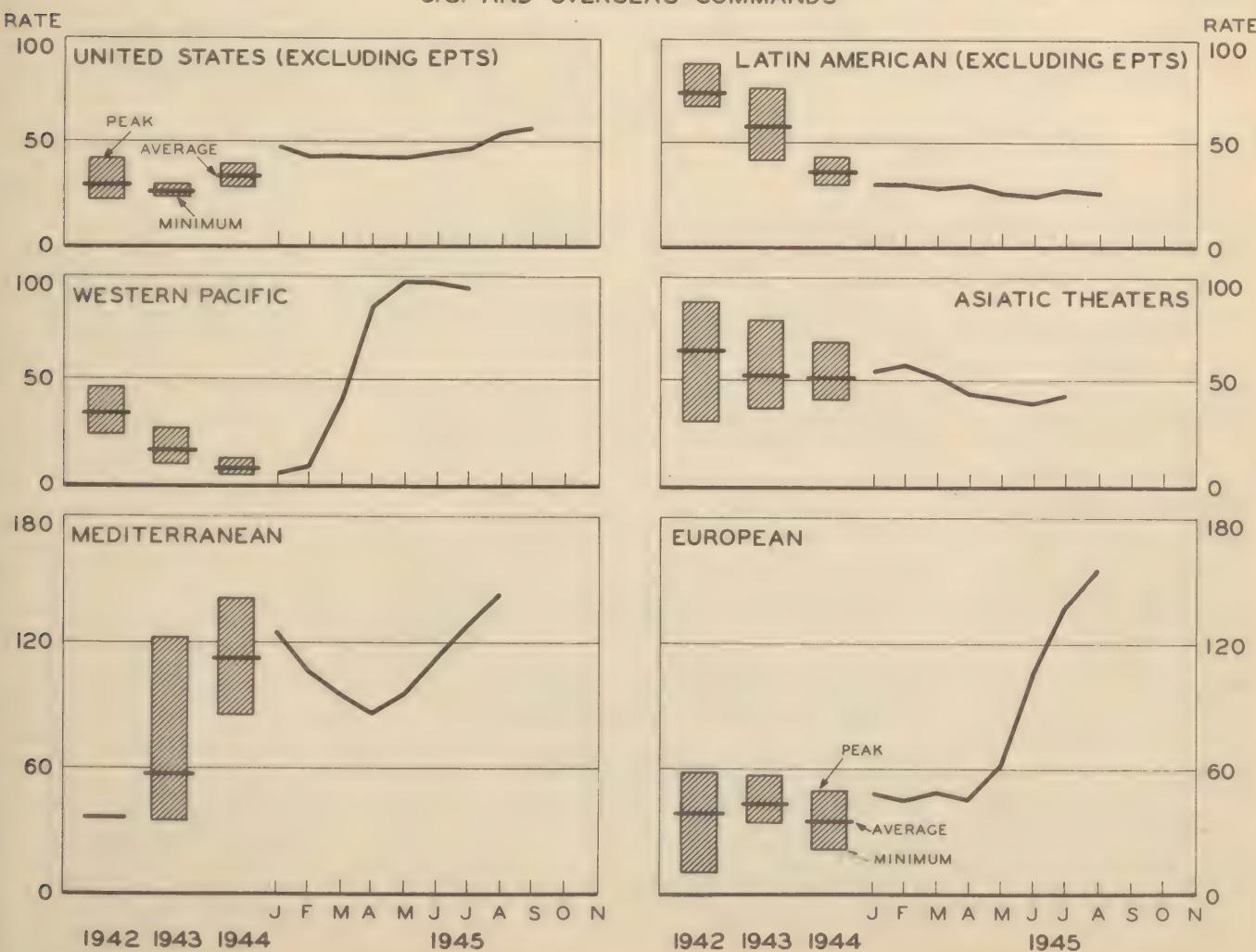
# DISEASE AND INJURY

## INCIDENCE OF VENEREAL DISEASE

The accompanying chart reveals that the current trend of venereal disease admissions is quite unfavorable in many theaters. The bar for each year shows maximum, average, and minimum monthly rates for the year, while the line records the monthly rates for 1945 in each case. Although the rate for the Western Pacific appeared to have reached a plateau in May, it may rise higher in August and its future trend is difficult to predict. In the Mediterranean the admission rate continued to climb through August, reaching the highest rate in the history of the Theater. The similar but even steeper rise in the European Theater carried the rate to 136 per 1,000 men per year for July, and 171 for the first four weeks of August. In the Asiatic theaters the trend was favorable through July, but the end of the war in the Pacific may well increase exposure and thus cause the rate to rise there as in Europe. The long-term trend in Latin America is little short of remarkable, the August rate of 26 being less than forty percent of the minimum for 1942. Rates in the Caribbean are even lower, the August 1945 figure being 17. In the Z/I the current rates are the highest of the war. After following a gradually upward trend throughout 1944, they stabilized at about 44 admissions per 1,000 men per year during 1945. However, with the influx of large numbers of returnees, the rate again resumed its rise and reached 53 in August and 56 in September. Apart from redistribution stations and assembly centers the Z/I rate for August was only about 45. Although comparable information is not available for September, there is every reason to believe that much of the recent rise reflects the increased exposure of returnees.

As was noted in *HEALTH* for April, the movement of noneffective rates in time is generally more favorable than the admission rates would suggest, because the average days lost per case has been falling. It is of interest to note, therefore, that the number of venereal disease patients remaining at the end of the various months increased from 0.6 per thousand strength for April to 1.1 for July in the European Theater, and from 0.2 for January to 1.3 for July in the Southwest Pacific, but fell slightly from 1.1 for April to 0.9 for August in the Mediterranean. In the Caribbean it fell from 1.1 for January to 0.4 for August.

**VENEREAL DISEASE, ADMISSIONS PER THOUSAND MEN PER YEAR  
U.S. AND OVERSEAS COMMANDS**



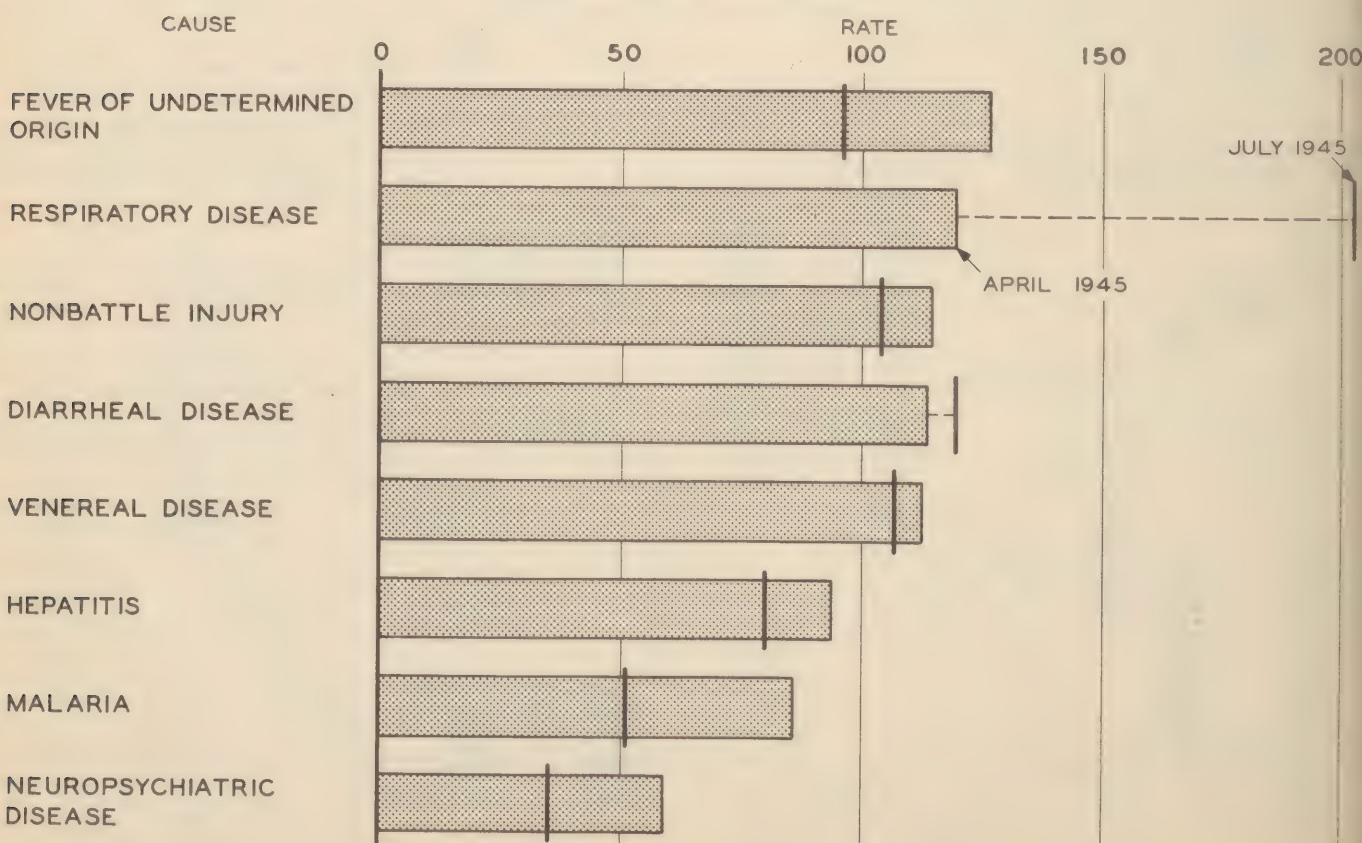
# DISEASE AND INJURY

## MORBIDITY RATES IN THE PHILIPPINES

In HEALTH for June considerable point was made of the spectacular increases in admission rates for certain diseases in the Philippines, notably venereal disease, diarrheal disease, hepatitis, respiratory disease, and malaria. Some of the rates shown there for April were the highest ever reported by the theater for any large number of men, and the presence of upwards of three-quarters of a million troops in the Philippines continues to invest the morbidity trend there with great interest. The accompanying chart records the changes which have occurred since April, July being the latest month reported by the theater. The causes listed there account for about 65 percent of all nonbattle admissions.

The monthly rates for all disease admissions in the Philippines are 1,174 for April, 1,266 for May, 1,243 for June, and 1,129 for July, only four percent below the April total. However, the improvement would have been significant had the respiratory rate not risen steadily from 120 in April to 203 in July. As the chart shows, the only other exception was diarrheal disease, for which the July rate is about five percent above that for April. It should be pointed out that both March and June had much higher rates of 171 and 165 respectively. For amebic dysentery alone the rates are 20 for April and 23 for July in comparison with five for January. There is no evidence that satisfactory sanitary controls had been established by July, and there is no reason why this situation should be allowed to continue under peace-time conditions. Venereal disease incidence ceased to increase appreciably after April, being fairly stable in May, June, and July and slightly downward in trend. An intensive control program is in operation. Hepatitis increased to 105 in May but had fallen to 80 by July. For Sixth Army troops on Luzon hepatitis admissions had declined from 138 in April to 98 in July. Certain combat divisions continued to report very high rates in July, e.g. 438 for the Americal, 194 for the 43rd Infantry, 170 for the 33rd Infantry, and 165 for the 40th Infantry Division. The only low rates were those of 27 for the 77th Infantry and 28 for the 81st Infantry Division, recent arrivals from Okinawa and Oahu. Malaria and neuropsychiatric disease both declined about 40 percent in the period under review. The reduction in the incidence of malaria reflects improved atabrine suppression following cessation of combat, while the lower neuropsychiatric rate also stems from the cessation of combat. The entire Western Pacific rate of 38 for neuropsychiatric admissions in July is the lowest ever recorded since reporting was placed on a firm basis in January 1944. Subsequent rates should be even more favorable if the European experience is a reliable guide.

ADMISSIONS PER THOUSAND MEN PER YEAR, SELECTED CAUSES  
PHILIPPINE ISLANDS



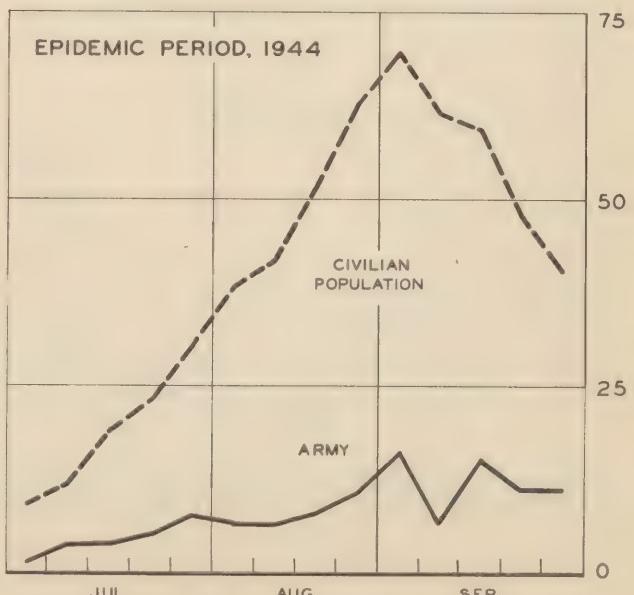
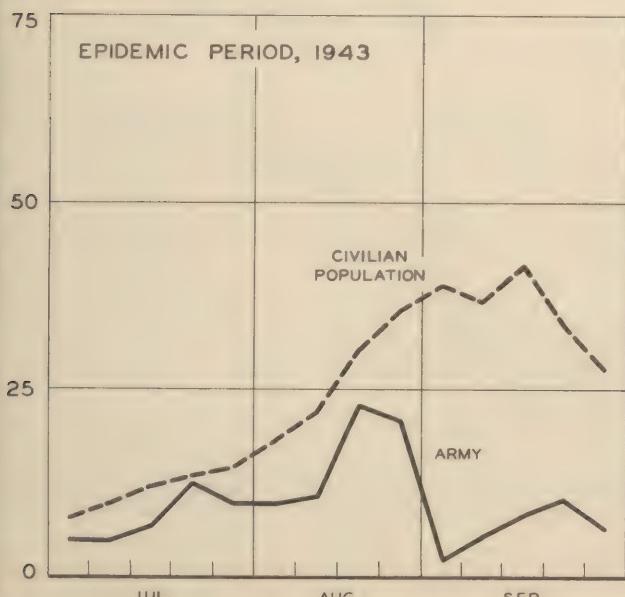
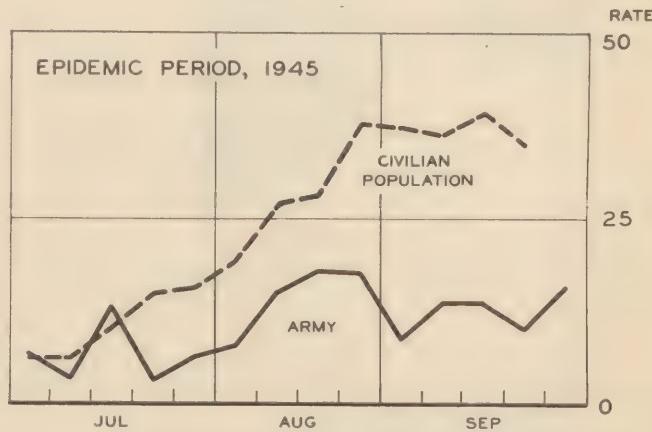
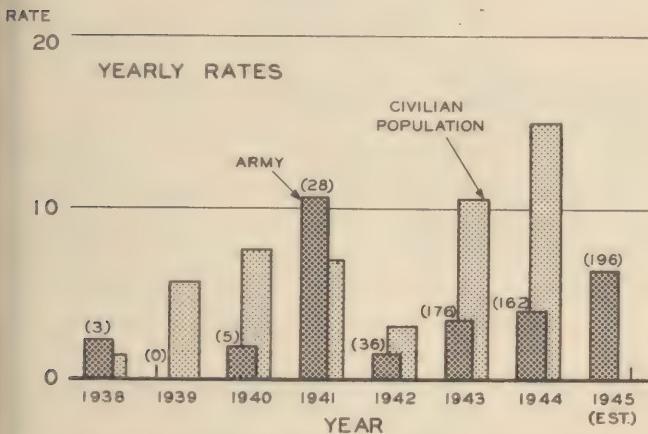
# DISEASE AND INJURY

## POLIOMYELITIS

During the war years, the incidence of poliomyelitis among troops in the United States has been well above the average pre-war level. Rates of zero to three per hundred thousand men per year have been superseded by rates of three to more than six. The first panel below gives the annual rates for the Army and the civilian population in the United States since 1938. The actual number of Army cases appears in parentheses at the top of each bar. The rate for 1945 is based upon reported cases for the first three-quarters of the year plus an estimate for the last quarter. During 1945 the civilian experience in the United States has dropped below that of 1944 whereas the Army rate rose above the 1944 level. However, even in 1945 Army rates continue to be far below civilian rates. During the epidemic period, roughly from July through September of each year, the Army count of 99 cases for 1945 compares with 85 for 1944. The civilian population, on the other hand, has reported about 7,600 cases during the epidemic period of 1945 and 13,800 in 1944. Civilian reporting is probably less complete than Army reporting. The remaining panels below compare the weekly incidence of poliomyelitis in the Army and the civilian populations during the epidemic periods of 1943, 1944, and 1945. The generally sporadic nature of current Army incidence is well illustrated by the fact that two-thirds of all the 1945 cases represent camps where only one or two cases have occurred thus far this year. Except for a definite outbreak in April in one camp which has had 21 cases this year only two camps have had as many as five cases in nine months.

Overseas the incidence of poliomyelitis has been higher this year than in 1944, with about 325 cases reported during the first seven months of 1945 as against 188 cases during the whole of 1944. Fifty-seven percent of the overseas cases this year have occurred in the Southwest Pacific, and 93 percent of these have been diagnosed in the Philippine Islands. There was also an outbreak in the Mediterranean with 34 cases in June and 15 more in July.

**POLIOMYELITIS ADMISSIONS PER HUNDRED THOUSAND PER YEAR  
CIVILIAN POPULATION AND ARMY IN THE CONTINENTAL U.S.**



~~RESTRICTED~~

~~CONFIDENTIAL~~

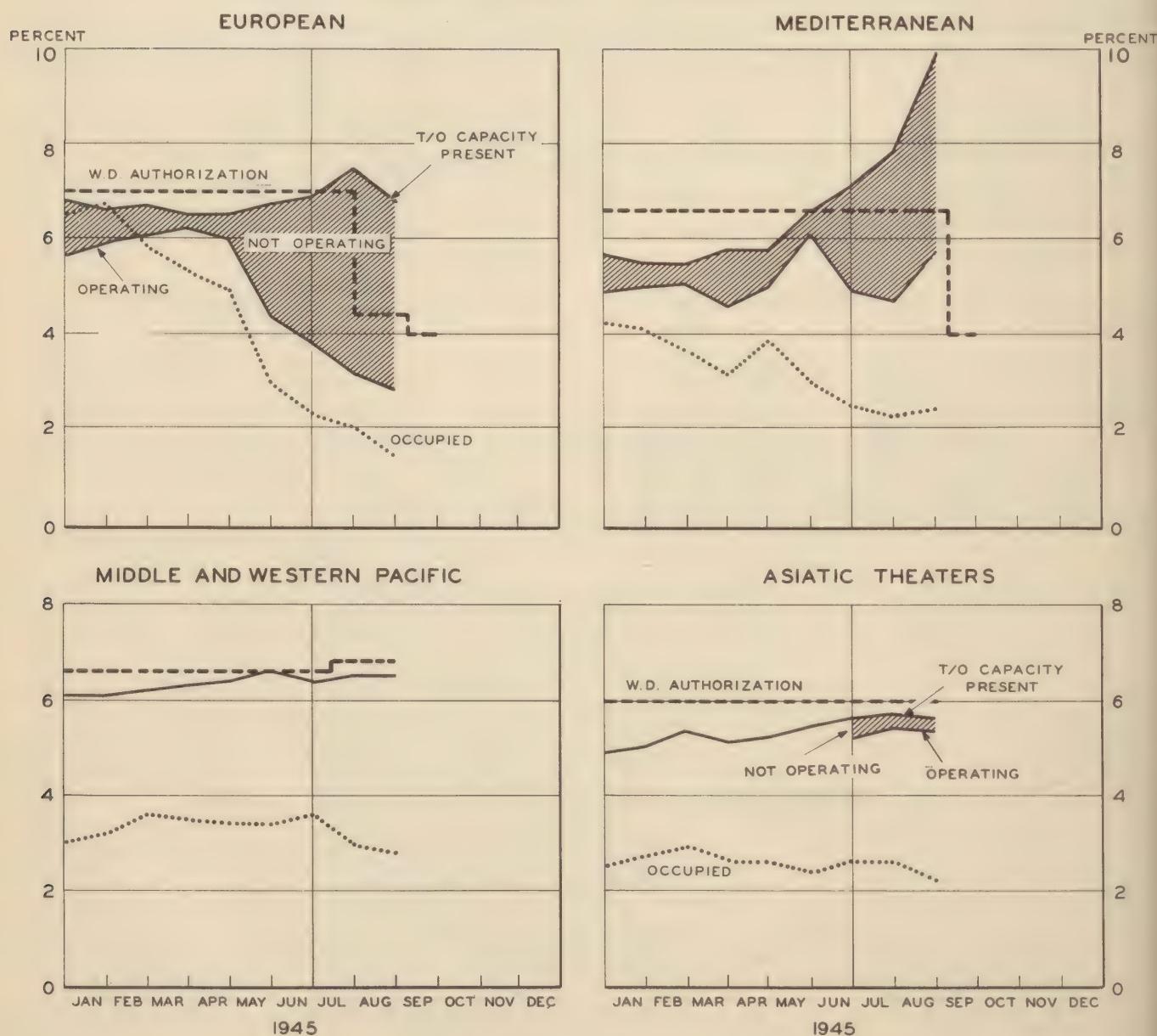
# HOSPITALIZATION

## OVERSEAS HOSPITALIZATION

At the end of August there were but 99,500 patients remaining in Army hospitals overseas, half the 31 May census. Fixed bed capacity fell to 288,200 during August, 16 percent below the 31 May count, a close parallel to the reduction of 18 percent in strength. The T/O capacity of units present in a theater no longer provides a meaningful index to the personnel present, for in many units scheduled for return to the Z/I only a token strength remains overseas. Very little significance attaches, therefore, to the large apparent excesses in T/O capacity reported by the European and Mediterranean Theaters in recent months. Some reductions in the percentage authorizations for fixed beds have already been made, and others are in prospect. Both the European and Mediterranean Theaters went on a 4.0 percent basis on 15 September, and the authorizations of 6.0 percent for the Middle Pacific and 7.0 percent for the Western Pacific are shortly to be replaced by 4.8 percent for the entire Pacific where the evacuation policy will be placed on a normal 120-day basis on 1 December. On 31 August 59 percent of the beds present in the European Theater, 42 percent in the Mediterranean, 47 percent in the Western Pacific, and five percent in the Asiatic Theaters, were not operating. The accompanying tables provide the details by theater for 31 August, and the chart below gives some of the more important points against the background of previous months in 1945.

## FIXED HOSPITALIZATION IN OVERSEAS THEATERS

BEDS AS PERCENT OF STRENGTH



~~RESTRICTED~~

# HOSPITALIZATION

**CONFIDENTIAL**

## OVERSEAS HOSPITALIZATION (Continued)

The fixed hospital population declined to 87,400 during August, 21 percent below the count for 31 July and 46 percent below that for 30 June. In addition 5,800 prisoners of war and others were occupying hospitals for non-Army patients on 31 August. Eighty-one percent of these non-Army patients were in the European Theater where their number was 38 percent below the census at the end of July. In the European Theater only 2,300 PW's were in Army hospitals, 2,800 fewer than at the end of July. The number of fixed beds occupied in the European Theater was equivalent to only 1.4 percent of troop strength, barely one-fifth the peak of 6.7 percent at the end of January. On 31 August only 14 wounded patients remained in the European Theater and only about 1,500 in all overseas theaters.

Only 12,100 patients were in nonfixed hospitals overseas on 31 August, capacity being only 16 percent filled. On 31 July there were 18,700 patients and 22 percent of the capacity was occupied. However, in the Western Pacific 47 percent of the nonfixed capacity present was occupied on 31 August, a reduction from 72 percent on 31 July when mobile beds were more crowded.

The chart on page 20 summarizes the status of beds in field, general, and station hospitals and convalescent centers which were in the European, Mediterranean, and Africa-Middle East Theaters and the Persian Gulf Command on 1 June. By 10 October these commands had returned 89,200 beds to the Z/I, 62 percent of which had been inactivated here by that date. The 10 October schedule of actions pending in the near future called for the return to the Z/I and inactivation here of 37,800 of the fixed beds remaining in these theaters and for

**FIXED BEDS AVAILABLE AND OCCUPIED**  
Number of Beds, 31 August 1945

Theater	W. D. Author- ization	T/O Present		Operating		Occupied <u>d</u> /
		Number <u>c</u> /	Percent of Author- ization	Number <u>d</u> /	Percent of T/O Present	
ALL THEATERS	237,797	288,225	121.2	e/	e/	87,389
American <u>a</u> /	4,310	4,475	103.8	4,755	106.3	2,193
European	91,705	141,850	154.7	57,950	40.9	28,845
Mediterranean	15,023	22,500	149.8	13,000	57.8	5,496
Pacific	106,113	101,000	95.2	e/	e/	43,686
Asiatic Theaters	18,033	16,825	93.3	15,975	94.9	6,455
Africa-Middle East <u>b</u> /	2,613	1,575	60.3	1,585	100.6	714

Beds as Percent of Strength and Percent Occupied

Theater	Strength (Thousands) <u>f</u> /	W. D. Author- ization	T/O Present <u>g</u> /	Beds Occupied as		
				Percent of Strength	Percent of T/O Present	Percent of T/O Operating
ALL THEATERS	4,366	5.5	6.6	2.0	30.3	e/
American <u>a</u> /	144	3.0	3.1	1.5	49.0	46.1
European	2,084	4.4	6.8	1.4	20.3	49.8
Mediterranean	228	6.6	9.9	2.4	24.4	42.3
Pacific	1,565	6.8	6.5	2.8	43.3	e/
Asiatic Theaters	301	6.0	5.6	2.1	38.4	40.4
Africa-Middle East <u>b</u> /	44	6.0	3.6	1.6	45.3	45.0

a/ Includes Alaskan Department and excludes Eastern and Central Canada.

b/ Includes Persian Gulf Command.

c/ T.L.O.S. dated 1 September 1945.

d/ Reported by theaters telegraphically for 31 August 1945. Middle Pacific for 10 August.

e/ Not available.

f/ Geographic strength by theater. Strength for Asiatic Theaters includes 70,000 Chinese in India-Burma.

**CONFIDENTIAL**

## HOSPITALIZATION

CONFIDENTIAL

## OVERSEAS HOSPITALIZATION (Continued)

the inactivation of almost 8,000 beds overseas. The movement of hospital units from the Pacific and Asiatic theaters has not as yet assumed large proportions. However, by 10 October 3,350 beds were scheduled for return to the Z/I for inactivation, and 10,900 had been scheduled for inactivation in the theaters.

NONFIXED BEDS AVAILABLE AND OCCUPIED  
Overseas Theaters, 31 August 1945

Theater	T/O Present		Operating		Number b/ Present	Total Occupied		
	Number a/ Present	Percent of Strength	Number b/ Present	Percent of T/O Present		Percent of T/O Present	Percent Operat- ing	Percent of Strength
ALL THEATERS	77,000	1.8	c/	c/	12,119	15.7	c/	0.3
European	50,775	2.4	21,250	41.9	5,771	11.4	27.2	0.3
Mediterranean	6,850	3.0	1,900	27.7	184	2.7	9.7	0.1
Pacific	14,400	0.9	c/	c/	5,462	37.9	c/	0.3
Asiatic Theaters	4,975	1.7	1,225	24.6	702	14.1	57.3	0.2

PATIENTS REMAINING IN NUMBERED FIXED AND NONFIXED HOSPITALS  
Overseas Theaters, 31 August 1945

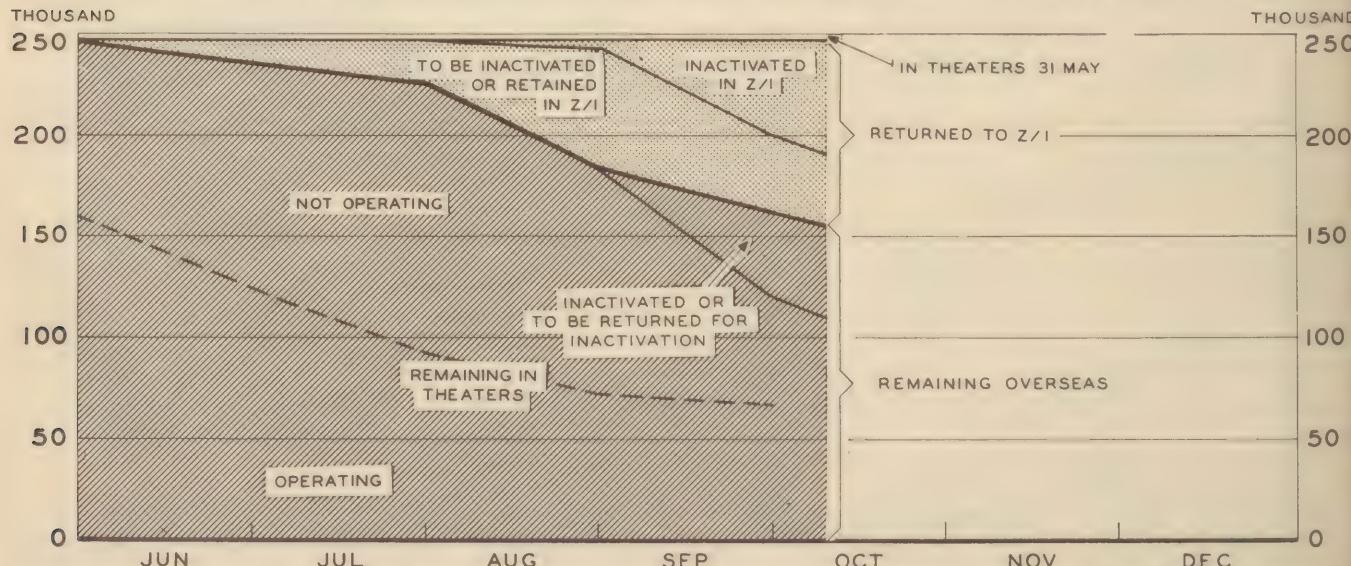
Theater	Total Patients Remaining	Percent Remaining in		Percent Who Were		
		Fixed Units	Nonfixed Units	Army Patients	PW's	Others
ALL THEATERS	99,508	87.8	12.2	c/	c/	c/
American	2,193	100.0	-	92.0	-	8.0
European	34,616	83.3	16.7	87.6	6.6	5.8
Mediterranean	5,680	96.8	3.2	73.2	5.4	21.4
Pacific	49,148	88.9	11.1	c/	c/	c/
Asiatic Theaters	7,157	90.2	9.8	83.5	-	16.5
Africa-Middle East	714	100.0	-	87.4	-	12.6

a/ T.L.O.S. dated 1 September 1945.

b/ Reported by theaters telegraphically for 31 August 1945. Middle Pacific for 10 August.

c/ Not available.

## DISPOSITION OF FIXED BEDS\* IN THE EUROPEAN THEATERS, 1945



\* Including field hospitals, some of which are mobile. Units in European, Mediterranean, and Africa Middle East Theaters and Persian Gulf Command are included.

## HOSPITALIZATION

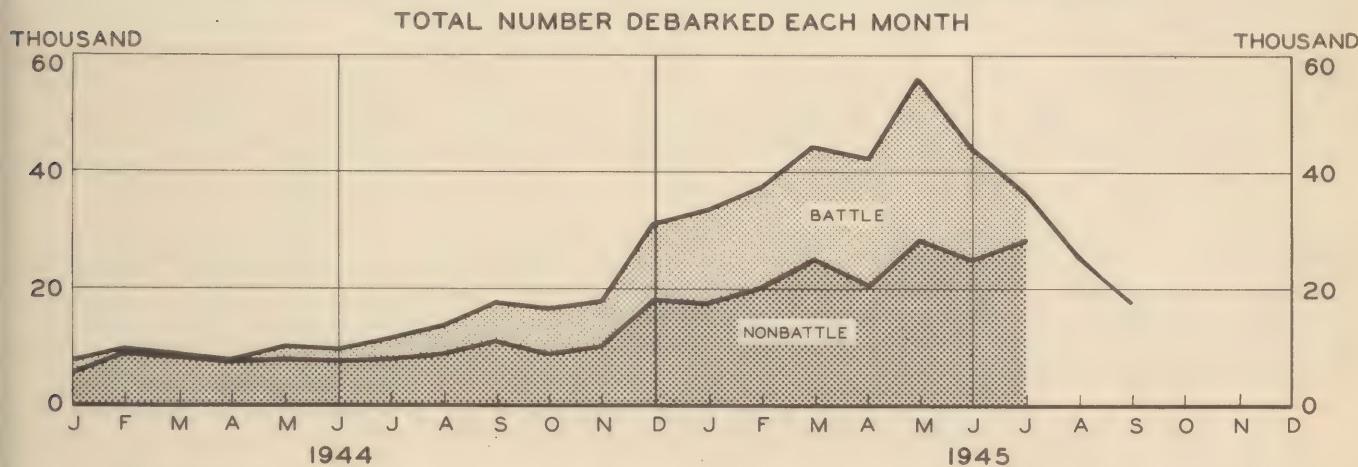
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TREND OF EVACUATION FROM OVERSEAS

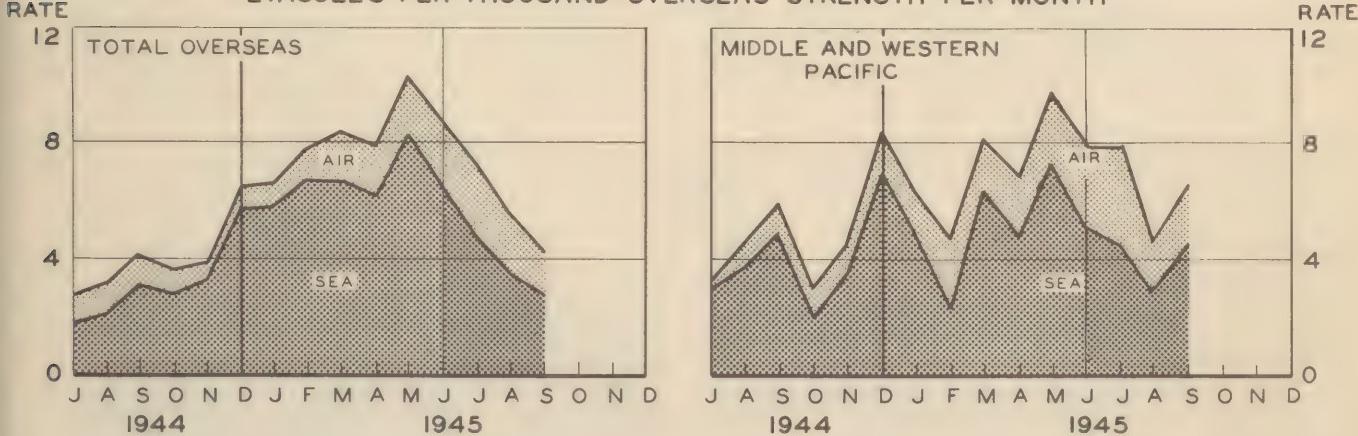
During September the number of Army patients debarked in the Z/I from overseas declined for the fourth successive month. The provisional total of 18,000 is 8,000 below the August count and is the smallest since November 1944. RAMP's are excluded. The lift from the European Theater was down to 5,000 from 16,000 in August, lower than in any month since September 1944. From Army Forces Pacific, however, the number of patients was 11,000, well above the August lift. The Pacific hospital census of less than 50,000 would be expected to support evacuation at this level for only a few months. Evacuation policies in the major theaters were as follows on 1 October: 60 days for the Pacific, 120 days for the European Theater, and 120 days for the Mediterranean Theater. The Asiatic theaters have been instructed to avail themselves of all possible lift in order to reduce their hospital population without regard for evacuation policy.

The volume of Army evacuees brought back by air declined about 2,000, but more than 1,000 non-Army patients and RAMP's were also returned to the Z/I by the Army Transport Command, and the net decline was only about 1,400 patients. However, since water evacuation declined to 12,000, the lowest since August 1944, the proportion of air evacuees remained at about 33 percent. The charts below trace the monthly course of evacuation in both absolute and relative form for all theaters and in rate form for the Pacific.

## EVACUATION OF ARMY PATIENTS FROM OVERSEAS



## EVACUEES PER THOUSAND OVERSEAS STRENGTH PER MONTH



CONFIDENTIAL

# HOSPITALIZATION

## HOSPITALIZATION IN THE ZONE OF INTERIOR

A total of 18,261 overseas patients were processed through debarkation hospitals during the month of September. This represents a reduction of approximately 8,000 from the number received in August. The entire decline is accounted for by the drop in evacuations from the ETO. West Coast debarkations during September totalled 11,421, an increase of some 3,400 over August debarkations, resulting from the clearing out of Pacific hospitals. It is expected that October evacuations from the Pacific will somewhat exceed September as the remaining battle wounded are moved from the theater. Total debarkations from all theaters during the month of October will probably approximate 20,000.

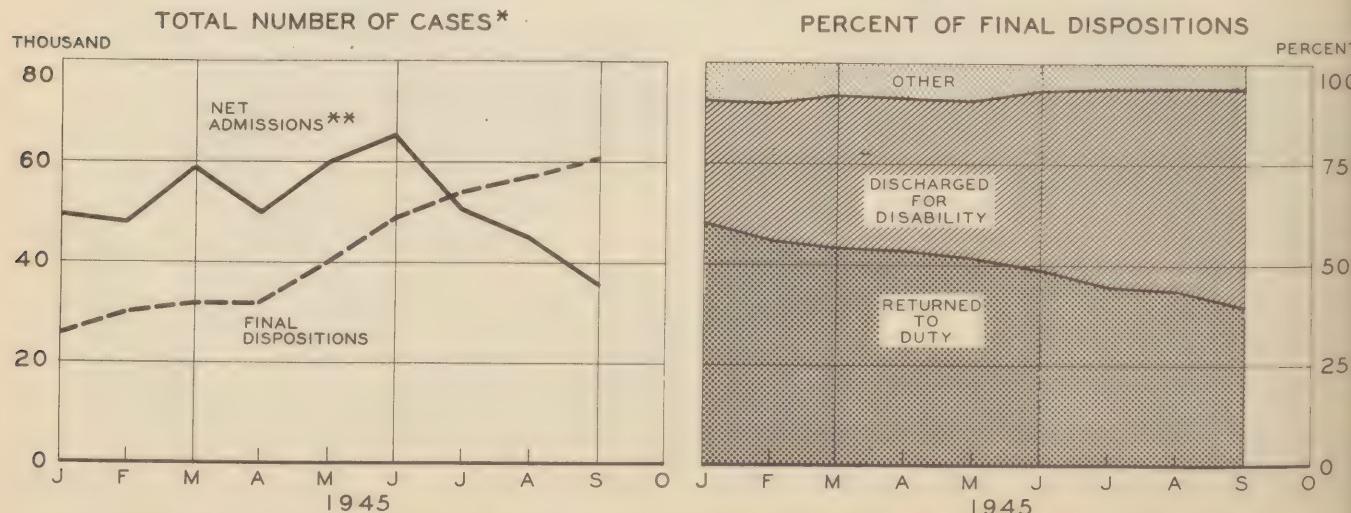
There were at the end of September 200,513 patients remaining in the general and convalescent hospitals, of which approximately 148,000 were in bed and 53,000 were on furlough. This total represents a reduction of slightly more than 25,000 from the comparable August figure. Major portion of this decline occurred in the general hospitals. The period has now been reached where increasing numbers of long time cases are completing treatment and being discharged. However, in contrast to the substantial reduction in patient load overall is the considerably slower reduction in general hospital beds occupied. This results from the return of patients on leave or furlough to the hospitals for the completion of their treatment and discharge.

September witnessed the all time high in dispositions during any four-week period from the general and convalescent hospitals. The total number of patients disposed of during the month was 60,715 of which an estimated 44,000 were overseas patients. It is expected that dispositions will continue at a high rate for the next two to three months as the bulk of the overseas patients received in the Zone of Interior during the first months of this year are disposed of. The Surgeon General in a recent memorandum has requested continued pressure to obtain disposition of patients as soon as maximum hospitalization has been reached in view of projected release of Medical Department personnel, particularly doctors.

Patients remaining in general hospitals at the end of September totalled 166,625, a decrease of approximately 17,000 from the end of August figure. Eleven thousand of this decrease was in the patients on furlough and leave, while only 6,000 was in the number of beds occupied. This reflects the continuing pressure to bring patients formerly on leave or furlough into the hospitals to effect disposition as quickly as possible. Beds occupied in general hospitals totalled over 120,000, a figure comparable to the load being carried in May 1945 shortly after V-E Day.

There were no changes in the authorized patient capacities of the hospitals during September. Plans were completed for carrying out the closure of 20 general hospitals by the end of December. This will result in a reduction of 40,000 beds in the total capacity of the general hospitals. A survey conducted during September of the estimated probable disposition of patients remaining in the hospital by specialty indicates that only 6,500 patients remaining in the hospitals scheduled for closure will require transfer to other general hospitals for the completion of their treatment. These will be principally general and orthopedic sur-

## ADMISSIONS AND DISPOSITIONS OF PATIENTS IN GENERAL AND CONVALESCENT HOSPITALS



\* Adjusted to four-week months.

\*\* Total admissions less dispositions by transfer.

# HOSPITALIZATION

## HOSPITALIZATION IN THE ZONE OF INTERIOR (Continued)

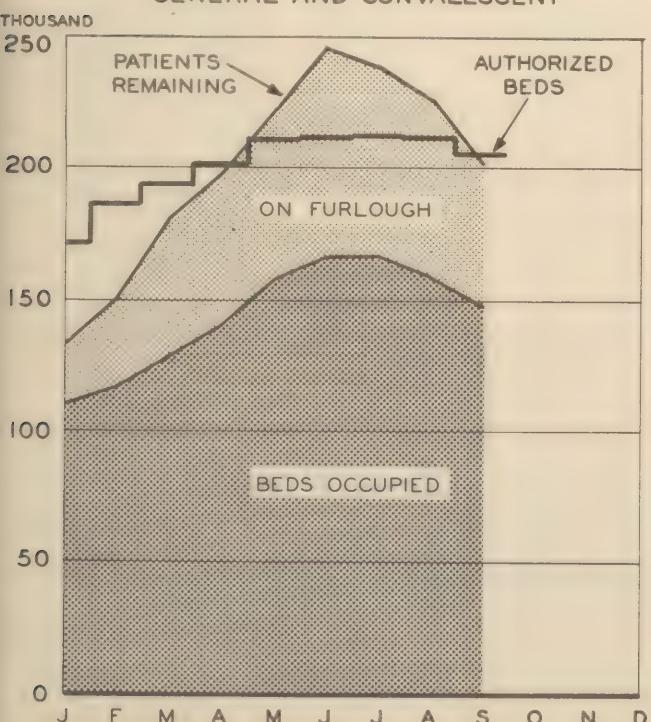
gery and neurosurgery patients. Arrangements are now being made to determine the residence and the types of specialized treatment required for the group that will require transfer. This will allow the Medical Regulating Officer to plan the allocation of the necessary beds and coordinate the movement of these patients. No attempt will be made to move patients who will complete their hospitalization prior to 31 December. However, it is believed that through the early transfer of the groups which will require hospitalization beyond 31 December 1945 closure of many of the hospitals in advance of that date can be accomplished. This would contribute substantially to personnel economies.

Patients remaining in convalescent hospitals at the end of September totalled 33,888, of which approximately 27,000 were present in the hospital and 7,000 were on leave or furlough. The decline in the total patient load of convalescent hospitals has been rapid due to the falling off of convalescent patients admitted direct from the debarkation ports and in the number of patients being transferred from the general hospitals. The reduced general hospital transfers results very probably from the increasing desire of patients to be discharged from the Army at the general hospital rather than be transferred to a convalescent hospital for convalescence and disposition. In view of this decreasing patient load in convalescent hospitals, a schedule of reduced capacities has been worked out as a result of which the total capacity of the convalescent hospitals was reduced from 50,000 to 43,500 as of 1 October, with further reductions for each subsequent month. This schedule will be accelerated if the decline in the patient load indicates. Two convalescent hospitals -- Pickett and Wakeman -- scheduled for closure by 31 December 1945, have been completely blocked for the receipt of new patients.

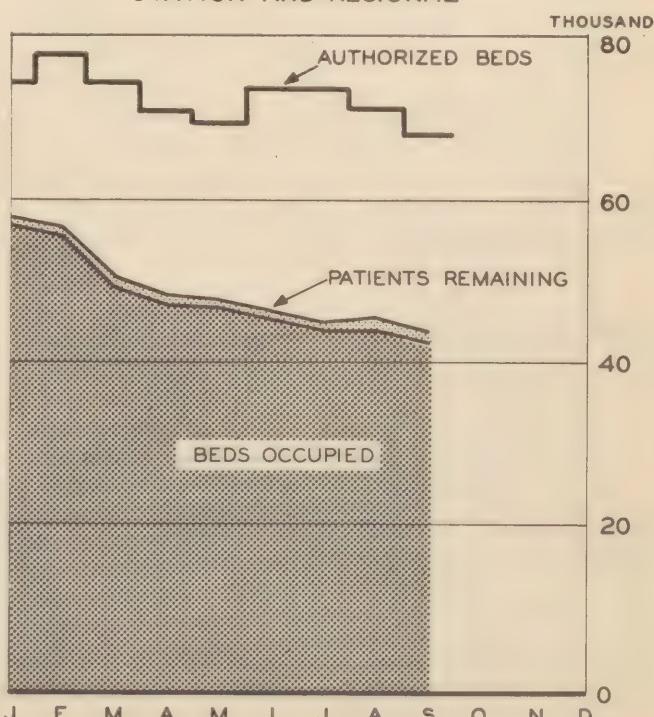
Beds authorized in station and regional hospitals at the end of September totalled 67,774, a reduction of about 2,900 beds since the end of August. This reduction results principally from the closing of several POW station hospitals. Only a slight reduction in the patient load of the regional and station hospitals occurred during the month.

Total personnel required to operate the ZI hospitals decreased by over 5,000 during September, the first decline during the year. This signified the beginning of a scheduled personnel contraction coincident with the decline in patient load. Personnel assigned decreased by over 7,000, or 2,000 more than the decline in requirements. This reduction reflects The Surgeon General's expressed policy to effect separation of all eligible personnel as rapidly as is consistent with the maintenance of established medical standards.

## HOSPITAL CAPACITY AND PATIENT LOADS, Z/I HOSPITALS, 1945 GENERAL AND CONVALESCENT



## STATION AND REGIONAL



# HOSPITALIZATION

## HOSPITALIZATION IN THE ZONE OF INTERIOR (Continued)

### SUMMARY ASF HOSPITALIZATION IN THE ZONE OF INTERIOR End of September 1945

Type of Hospital	Patient Capacity		Patients Remaining		Beds Occupied	Personnel Shortages c/		
	Authorized	Effective a/	Number b/	Percent of Effective Beds		MC	ANC	Total
Total	274,198	247,358	244,078	98.7	189,943	- 32	- 1,150	6,478
General	162,924	152,279	166,625	109.4	120,915	42	- 660	6,733
Convalescent	43,500	43,500	33,888	77.9	27,007	107	- 23	239
Regional	31,594	25,275	23,609	93.4	22,328	- 43	- 247	195
Station d/	36,180	26,304	19,956	75.9	19,693	- 138	- 220	669

a/ Less debarkation beds and 20 percent for dispersion in regional and station hospitals.

b/ Data exclude patients in triage at debarkation hospitals.

c/ Civilian nurses included. Overages are denoted with a minus sign (-) in all columns.

d/ Includes station hospitals under the Chief of Transportation.

### BEDS AUTHORIZED AND PATIENTS REMAINING IN ASF HOSPITALS BY TYPE OF CARE AND TYPE OF HOSPITAL a/ End of September 1945

Type of Patient	Beds Authorized	Patients Remaining				
		Total	General	Convalescent	Regional	Station b/
Total	260,253	244,078	166,625	33,888	23,609	19,956
General-Convalescent Care	169,461	172,244	138,718	33,526	-	-
Evacuees		159,542	126,501	33,041	-	-
Z/I		12,702	12,217	485	-	-
Regional - Station Care	76,701	57,843	18,723	337	22,083	16,700
Regional	12,461	10,272	3,846	-	6,426	-
Station	64,240	47,571	14,877	337	15,657	16,700
Non-Army	14,091	13,991	9,184	25	1,526	3,256
POW	9,163	9,814	6,629	12	867	2,306
Civilians	2,809	2,932	1,522	13	533	864
Veterans Administration	1,675	723	641	-	78	4
Other	444	522	392	-	48	82

a/ Excludes debarkation beds and patients.

b/ Includes hospitals under the Chief of Transportation.

#### Summary

Major trends in Zone of Interior hospitalization during September can be summarized as follows:

- a. Inflow of overseas patients continues to decline although evacuation of battle wounded from the Pacific is not yet complete.
- b. The patient load in the general and convalescent hospitals declined substantially as the period of peak dispositions was reached. Bed occupancies in the general hospitals remain high.
- c. Plans have been completed for the closure of 20 general hospitals and two convalescent hospitals by 31 December. Only very few patients will remain to be transferred.
- d. Beds authorized in station hospitals were reduced by about 2900 during the month and the patient load declined slightly.
- e. Decline in personnel requirements and assignments reflects the declining load and increasing separations.

# STATISTICAL TABLES

**RESTRICTED**

## STATISTICAL TABLES

Admission rates for selected diseases and for nonbattle injury in the United States and in overseas theaters are shown in the tables on the following pages. The rates include cases admitted to hospital or confined to quarters for a day or more, and have been derived from AGO Form 8-122 (formerly MD Form 86ab), both regular and telegraphic, submitted to The Surgeon General by each overseas theater or lesser command, and by posts, camps, and stations in the United States. Only the major overseas areas are shown separately, but the total overseas rates are based upon a complete consolidation. The rates for each month are based upon the experience of four or five weeks depending upon the number of Fridays in a month. Admission rates for wounded in action, presented in the table below, pertain to calendar-month periods and are derived from The Adjutant General's report, Battle Casualties of the Army, which covers hospital admissions only. The rates in each case apply to all Army strength in the particular area; air, ground, and service. Rates computed from incomplete reports and those derived from the weekly telegraphic reports are distinguished from those based on the final monthly report.

The venereal disease rates derived from AGO Form 8-122 are generally higher than those based on the Monthly Venereal Disease Statistical Report. Venereal infections contracted prior to service have been excluded from the rates. Tentative neuropsychiatric admission rates are presented for 1944 and 1945. Not systematically reported on AGO Form 8-122 until late in 1943, these rates may not be as firm as those for communicable diseases. Malaria rates for the continental United States reflect only infections acquired in the United States; rates based on all admissions are much higher. They also measure diagnosed malaria only, but include both primary attacks and recurrences insofar as these are reported as malaria. A variable amount of malaria, differing from theater to theater, is at first reported as fever of undetermined origin. Many of these cases are later correctly diagnosed and enter into the rates. Since the system of reporting does not make it possible to subtract such cases from the undiagnosed category, some duplication continues to exist.

**WOUNDED IN ACTION, AS REPORTED TO THE ADJUTANT GENERAL  
Hospital Admissions per Thousand Men per Year**

Month and Year	Total <u>a</u> / Overseas	Overseas' Commands						
		North American	Latin American	ETO <u>b</u> /	MTO	Pacific <u>c</u> /	CBI	Africa- Middle East
1943 Average	23	6	0	7	62	15	4	4
1944 Jan-Jun	45	0	0	44	108	23	14	9
Jul	143	-	-	269	94	30	24	19
Aug	100	-	-	189	73	14	8	5
Sep	112	-	-	174	165	20	2	4
Oct	96	0	-	118	170	52	3	-
Nov	134	-	-	235	36	43	5	0
Dec	118	-	-	189	30	48	7	-
1944 Jul-Dec	117	0	-	193	99	35	8	5
1944 Average	87	0	-	139	104	30	11	7
1945 Jan	126	-	-	202	14	52	14	-
Feb	105	-	-	134	59	100	15	0
Mar	105	-	-	156	34	61	4	0
Apr	111	0	-	113	147	140	1	-
May	30	-	-	6	3	105	1	-
Jun	14	-	-	0	0	51	0	-
1945 Jan-Jun	82	0	-	101	44	85	6	0

a/ Including casualties among men en route.

b/ Excluding Iceland.

c/ SWPA and POA combined.

Dash is used to denote no admissions, zero to denote a rate of less than 0.5.

**RESTRICTED**

# STATISTICAL TABLES

## STATISTICAL TABLES (Continued)

### ADMISSIONS TO HOSPITAL AND QUARTERS Rates, Per Thousand Men Per Year

Month and Year	United States	Overseas Commands								ME and PGC
		Total	Alaska	Carib- bean	ETO a/	MTO	POA	SWPA	Asiatic	
<b>ALL DISEASE</b>										
1942 Average	664	676	667	823	693	452	519	821	1,048	1,330
1943 Average	739	889	624	670	837	943	971	1,046	991	1,107
1944 Jan-Jun	619	695	566	528	578	812	600	902	967	949
Jul-Dec	495	623	351	536	440	880	513	804	1,152	842
Average	563	654	478	531	492	846	561	840	1,077	896
1945 Jan	603	656	337	529	605	878	420	799	728	658
Feb	626	649	363	587	577	790	526	905	652	554
Mar	592	612	384	546	530	714	412	973	647	631b/
Apr	543	587	411	553	469	657	414 b/	1,058	710	573
May	541	(643)b/	658	515	531	600	(387)b/	1,144	712	582
Jun	515	(655)b/	435	629	532	704		1,128	788	532
Jan-Jun	569		426	562	538	726		1,006	707	587
Jul	471	(652)b/	381	572	528	654	542	1,038 b/	875	577
Aug	478	(654)	346	531	501	645				620
Sep										
Oct										
Nov										
Dec										

### NONBATTLE INJURY

1942 Average	91	123	152	107	109	96	104	176	80	158
1943 Average	80	136	182	105	100	149	131	171	84	140
1944 Jan-Jun	69	114	145	75	85	145	118	151	95	107
Jul-Dec	66	112	100	61	105	131	102	132	97	92
Average	67	113	127	68	97	138	111	139	96	99
1945 Jan	55	141	102	60	174	103	92	104	105	69
Feb	50	105	94	67	114	88	84	103	99	73
Mar	49	102	109	61	104	89	71	128	105	69 1/2
Apr	48	108	100	65	113	98	92 b/	115	104	64
May	49	(107)b/	84	57	112	97	(87)b/	119	91	59
Jun	53	(91)b/	92	59	87	85		113	83	62
Jan-Jun	51		97	61	115	93		114	98	66
Jul	48	80 b/	89	54	71	72	95	104 b/	80	53
Aug	44	(76)	90	50	56	62				71
Sep	36 b/									
Oct										
Nov										
Dec										

a/ Excluding Iceland.

b/ Based on Incomplete Reports.

( ) Telegraphic Reports.

# STATISTICAL TABLES

## STATISTICAL TABLES (Continued)

### ADMISSIONS TO HOSPITAL AND QUARTERS Rates Per Thousand Men Per Year

Month and Year	United States	Overseas Commands								
		Total	Alaska	Carib- bean	ETO a/	MTO	POA	SWPA	Asiatic	ME and PGC
<b>ALL VENEREAL DISEASE</b>										
1942 Average	29	32	7	74	38	36	12	32	64	80
1943 Average	26	34	3	56	43	56	5	15	52	68
1944 Jan-Jun	30	37	3	33	26	96	6	9	53	60
Jul-Dec	37	45	7	33	40	125	4	6	50	62
Average	33	42	5	33	35	111	5	7	51	60
1945 Jan	47	46	6	29	48	124	4	5	54	80
Feb	43	42	8	29	45	105	3	8	57	75
Mar	43	47	10	26	48	94	3	40	51	74 b/
Apr	43	51	8	27	46	85	3 b/	84	43	84
May	43		8	25	62	94		97	40	63
Jun	44		12	20	105	110		97	38	69
Jan-Jun	44		9	26	60	102		57	47	74
Jul	46		7	26	136	128	5	94 b/	42	79
Aug	53		8	17	155	142				73
Sep	56 b/									
Oct										
Nov										
Dec										

### DIAGNOSED MALARIA

1942 Average	0.6	33	0	99	0	11	12	52	165	127
1943 Average	0.2	96	0	37	3	54	208	245	181	123
1944 Jan-Jun	0.1	43	-	16	10	61	67	75	113	66
Jul-Dec	0.2	34	-	12	8	63	13	41	216	52
Average	0.2	38	-	14	9	62	43	53	174	59
1945 Jan	0.1	14	0	7	5	19	8	27	74	11
Feb	0.2	14	-	7	5	16	6	43	49	9
Mar	0.1	18	-	7	8	21	4	62	28	10 b/
Apr	0.2	23	-	9	11	28	5 b/	75	29	11
May	0.1		0	11	11	31		72	23	9
Jun	0.1		0	12	9	26		65	28	14
Jan-Jun	0.1		0	9	8	23		58	37	11
Jul	0.1		1	12	6	24	4	46 b/	33	14
Aug	0.1		-	8	3	15				13
Sep	0.1 b/									
Oct										
Nov										
Dec										

a/ Excluding Iceland.

b/ Based on incomplete reports.

Dash is used to denote no admissions, zero to denote a rate of less than 0.5.

# STATISTICAL TABLES

## STATISTICAL TABLES (Continued)

### ADMISSIONS TO HOSPITAL AND QUARTERS Rates Per Thousand Men Per Year

Month and Year	United States	Overseas Commands								ME and PGC
		Total	Alaska	Carib- bean	ETO a/	MTO	POA	SWPA	Asiatic	
<b>COMMON RESPIRATORY AND INFLUENZA</b>										
1942 Average	243	159	244	113	287	151	89	146	150	197
1943 Average	247	181	222	99	409	142	86	108	159	201
1944 Jan-Jun	198	174	245	84	225	185	97	90	177	254
Jul-Dec	85	100	105	77	92	138	70	78	176	182
Average	147	132	188	81	142	162	85	83	176	219
1945 Jan	167	146	106	67	166	190	70	95	135	180
Feb	192	144	135	71	157	182	60	128	135	149
Mar	167	122	115	65	125	152	54	125	131	164 b/
Apr	122	99	143	74	93	106	56 b/	131	130	127
May	124		417	75	87	79		139	136	92
Jun	101		182	193	63	70		145	163	88
Jan-Jun	145		177	95	112	132		128	139	132
Jul	77		90	150	56	61	99	180 b/	182	108
Aug	79		85	105	66	69				115
Sep	71 b/									
Oct										
Nov										
Dec										

### DIARRHEA AND DYSENTERY

1942 Average	8	28	5	19	17	33	34	57	120	185
1943 Average	12	66	8	16	12	132	43	70	146	170
1944 Jan-Jun	9	35	3	13	11	41	28	58	182	101
Jul-Dec	10	40	3	12	14	67	28	54	180	129
Average	9	38	3	13	13	54	28	55	181	115
1945 Jan	8	30	1	11	17	20	17	76	69	56
Feb	8	36	2	14	20	21	27	99	68	31
Mar	6	34	2	21	13	19	14	119	83	45 b/
Apr	6	33	3	14	15	18	18 b/	90	116	81
May	6		2	14	16	22		88	118	135
Jun	7		0	16	14	31		138	128	90
Jan-Jun	7		2	15	16	22		104	98	73
Jul	8		1	15	20	30	24	106 b/	151	120
Aug	7 b/		1	11	17	25				106
Sep										
Oct										
Nov										
Dec										

a/ Excluding Iceland.

b/ Based on Incomplete Reports.

# STATISTICAL TABLES

## STATISTICAL TABLES (Continued)

### ADMISSIONS TO HOSPITAL AND QUARTERS Rates Per Thousand Men Per Year

Month and Year	United States	Overseas Commands								
		Total	Alaska	Carib- bean	ETO a/	MTO	POA	SWPA	Asiatic	ME and PGC
<b>FEVER OF UNDETERMINED ORIGIN</b>										
1943 Average	c/	52	0	64	1	75	19	166	71	21
1944 Jan-Jun	c/	35	1	37	1	57	26	102	69	16
Jul-Dec	c/	40	0	31	3	85	13	80	174	37
Average	c/	38	1	34	2	71	20	88	131	27
1945 Jan	c/	24	0	20	4	39	5	70	87	12
Feb	c/	26	-	10	4	43	9	95	60	24
Mar	c/	29	0	10	6	41	3	117	56	31 b/
Apr	c/	29	-	9	8	43	8 b/	104	59	33
May	c/	-	0	10	9	38	-	113	70	35
Jun	c/	-	0	10	6	50	-	98	89	29
Jan-Jun	c/	-	0	12	6	42	-	100	70	28
Jul	c/	-	1	7	5	57	10	86 b/	102	50
Aug	c/	-	0	6	5	58	-	-	-	59
Sep	-	-	-	-	-	-	-	-	-	-
Oct	-	-	-	-	-	-	-	-	-	-
Nov	-	-	-	-	-	-	-	-	-	-
Dec	-	-	-	-	-	-	-	-	-	-

### NEUROLOGICAL AND PSYCHIATRIC DISORDERS

1944 Jan-Jun	29	29	11	21	24	37	26	48	23	27
Jul	32	59	10	16	84	52	27	58	16	31
Aug	36	50	12	18	76	28	25	48	17	21
Sep	46	41	13	25	40	50	32	53	16	19
Oct	48	56	13	23	65	82	32	39	21	21
Nov	47	60	13	27	85	47	28	41	23	16
Dec	47	56	12	22	72	39	29	53	20	26
Jul-Dec	45	53	12	22	69	50	29	49	19	22
Average	36	43	12	21	52	43	27	48	20	25
1945 Jan	50	43	14	25	51	32	35	43	19	20
Feb	49	39	9	27	36	31	25	70	20	15
Mar	50	40	13	29	39	31	25	74	22	20 b/
Apr	45	36	13	26	31	41	34 b/	60	24	11
May	49	-	9	20	15	13	-	67	22	8
June	43	-	14	20	13	13	-	49	26	13
Jan-Jun	48	-	12	24	30	27	-	60	22	15
Jul	39	-	11	23	10	12	25	38 b/	25	10
Aug	37	-	16	18	8	14	-	-	-	12
Sep	-	-	-	-	-	-	-	-	-	-
Oct	-	-	-	-	-	-	-	-	-	-
Nov	-	-	-	-	-	-	-	-	-	-
Dec	-	-	-	-	-	-	-	-	-	-

a/ Excluding Iceland. b/ Based on incomplete reports. c/ Not available.  
Dash is used to denote no admissions, zero to denote a rate of less than 0.5.

